



DEVON'S HEALTH

IN

1956

The Annual Report of the
County Medical Officer and
Principal School Medical Officer



Digitized by the Internet Archive
in 2017 with funding from
Wellcome Library

<https://archive.org/details/b29160042>

CONTENTS

	<i>Pages</i>
COMMITTEES	2-3
INTRODUCTION	4
GENERAL PUBLIC HEALTH—	
The Cost of the National Health Service	5
Population, Births and Deaths	6
Infectious Diseases and their Control	7
Tuberculosis	12
Food and Milk ; Water and Sewage	21-24
PERSONAL HEALTH SERVICE—	
Maternity Services	25
Infant Welfare „	27
Health Visiting „	29
Home Nursing „	30
Home Help „	31
Mental Health „	32
Ambulance „	36
Services for the Aged and Handicapped	37
SCHOOL HEALTH SERVICES—	
Medical Inspection and Treatment	41
Report of Principal School Dental Officer	45-48
Hearing Tests	49
Tuberculin “ Jelly ” Testing	52
Hygiene Examinations	52
Vision Tests and School Ophthalmic Service	52
Child Guidance	56
Handicapped Pupils	60
Hygiene: School Meals and Milk: Physical Education	64-68
APPENDICES—	
Medical Department Staff	69-71
Medical Officers of Health	72-73
Statistical tables	74-95

COMMITTEES

Health Committee

Chairman: Mrs. J. M. Phillips.

Vice-Chairman: Mr. Makeig-Jones.*

Chairman of the Council (ex-officio).

Vice-Chairman of the Council (ex-officio).

Major Bentley	Mr. Holmes	†Mr. A. D. Phillips
Mrs. Booth	Mr. F. P. Lee	‡Rev. H. S. H. Read
Mr. Daymond	Mr. Lowdon	Rev. J. W. Timms
Mr. Graves	Mr. Parsons	Mr. Vallance
Mr. Hedges	Mr. Pedlar	§Col. Ward
Mr. Hollow	Mrs. Perkin	Mr. Wilkey

Nominated by the following Bodies

Devon Branch, St. John Ambulance Association—Major T. W. Gracey.

Devon Local Dental Association—Mr. W. E. Woolcott

Devon Local Medical Committee—Dr. R. M. S. McConaghey
Dr. C. W. Wilson

Devon Nursing Association—Mrs. A. Makeig-Jones

Devon Pharmaceutical Committee—

Executive Council for Devon and Exeter—Mr. R. G. Hunt

§Chairman of Ambulance, †Appointments & General Purposes,
‡Mental Health, and *Nursing Sub-Committees.

Water and Sanitation Committee

Chairman: Major Allhusen.

Vice-Chairman: Mr. Voysey.

Chairman of the Council (ex-officio).

Vice-Chairman of the Council (ex-officio)

Mr. Alford	Mr. Glanville	Mr. Nancekivell
Mr. Carter	Mr. Hollow	Mr. Prowse
Mr. F. U. Crook	Mr. Makeig-Jones	Mr. Richards
Mr. Currey	Mr. Mitchell	Mr. Webber
Mr. Fishleigh	Mr. Mortimer	

Additional Members (2)

Mr. D. C. Philip

Mr. R. R. Willing

School Health Service Sub-Committee of the Education Committee

Chairman: Col. Ward.

Vice-Chairman: Mr. Shapland.

Chairman and Vice-Chairman of the Council (*ex-officio*).

Chairman and Vice-Chairman of the Education Committee
(*ex-officio*).

Mr. F. U. Crook	Mrs. Perkin	Mrs. Ratcliffe
Mr. Harvey	Mr. Pridham	Mr. Short
Mr. F. P. Lee		

Additional Members

Mrs. F. Hiley	Dr. Vanstone	Prof. S. H. Watkins
Miss Ragg		

MEDICAL DEPARTMENT,
IVYBANK,
45, ST. DAVID'S HILL.

EXETER.

18th July, 1957.

To the Chairman, Aldermen and
Members of the Devon County Council.

MR. CHAIRMAN, MY LORDS,
LADIES AND GENTLEMEN,

I have the honour to present my Annual Report for the year 1956.

The outstanding event of the year was the introduction of a vaccine against poliomyelitis. Although supplies and times of administration were limited I am glad to report that the best possible use was made of the material available. Vaccination against poliomyelitis was regarded as a top priority and in consequence some of our other work was not so fully covered as it might have been.

The Report of the Working Party on Health Visiting was published during the year and a summary of its findings as it affects Devon was presented to the Health Committee, but it was not found possible to increase the staff as recommended, in view of the present financial stringency. It is our hope that the position will be reconsidered in the near future as the Health Visitor is a key member of our team.

In the body of the Report there are remarks concerning the Underwood Report on the Provision for Maladjusted Children and on developments made in the Child Guidance Service in the County. A major change during the year was a concentration of the Psychological Services at Ivybank, which was made possible through the ready co-operation of the Education and Children's Departments. The centralization of this Service has been of great benefit, not only to those whom it serves but also to the staff.

Again I am happy to have the opportunity of thanking the members of the various voluntary organizations in the County who have helped us so much.. The co-operation of the other Departments of the County Council and the Heads of the County Schools is much appreciated. The Report is a composite document and I am glad to thank the contributors and all those associated with our work.

I have the honour to be,

Your obedient Servant,

W. J. DOYLE,

*County Medical Officer and
Principal School Medical Officer.*

THE COST OF THE NATIONAL HEALTH SERVICE

The Report of the Guillebaud Committee, which was enquiring into the cost of the National Health Service, was published early in the year. The Committee concluded that at this relatively early stage (the National Health Service is but seven years old) the emphasis should be on consolidation rather than further revolution, although a reservation signed by one of the members indicated that he felt the achievements had been brought about despite rather than because of the structure of the Service. The subsequent setting up of special committees to survey the Maternity Services was a tacit admission of the defects under a tripartite administration.

Quite apart from the interest occasioned by the Guillebaud Report the Council has been, as heretofore, very interested in the financial aspect of their services this year. It might therefore be worth mentioning that the figures for the national budget for 1956/57 show that the £537,000,000 expenditure on the Health Services represents 2/1d in every £1 of Government expenditure. At the same time the tax on tobacco yields £707,000,000 i.e. 2/9d in every £1 revenue. In other words, TAX ON TOBACCO MORE THAN PAYS FOR THE HEALTH SERVICES.

The most recent report of the Ministry of Health shows that of the £495,000,000 spent on the National Health Services in 1954/55 the proportion spent by the main branches was as follows:—

Hospital and Specialist Services	..	56½ %
General Medical, Dental, Pharmaceutical, and Supplementary Ophthalmic Services	29¼ %	
Local Health Authority Services	..	9 %
Miscellaneous, including compensation, superannuation, etc.	.. .. .	5½ %

It is also interesting to note that 78½ % of the income is derived direct from Exchequer grants, 12 % comes from patients either in direct payments or as part of National Insurance contributions, 5 % is paid by employees in the form of contributions to the Superannuation Fund, whilst only 4¼ % is met by the ratepayer.

Expenditure in Devon

It is not possible to make an accurate breakdown of the expenditure for the three main branches in Devon since of course the Regional Hospital Board covers the whole Region and the Local Executive Council embraces the County and Exeter City. There is no reason to believe that the apportionment would differ much from the National figures.

Our own Budget for 1956/57 shows that of our estimated expenditure of £530,700 some 26 % is spent on the Ambulance Service in transporting people to and from hospital. 41 % of our

expenditure goes on district nurses, midwives, and home help service, in support of the domiciliary medical treatment provided by the Local Executive Council. Some of our remaining expenditure obviously falls under the heading of care or after-care, but at the most a third of our money is devoted to prevention as such.

POPULATION

The County of Devon is the largest administrative county in England and Wales with an area of 1,649,207 acres, and is divided into 30 urban and 17 rural districts. The population has risen by 700 during the last year and is now 512,700 (including members of the Armed Forces stationed in the area).

BIRTHS AND DEATHS

There was a slight increase in the number of live births this year to 6,645. Figures are as follows:—

Births

Live Births: 6,645

Legitimate—total: 6,379 (males 3,253: females 3,126)

Illegitimate—total: 266 (males 141: females 125)

Rates: Crude 12.76 (corrected 14.77) compared with a birth rate of 15.7 for England and Wales.

Stillbirths: 151

Legitimate—total: 141 (males 81: females 60)

Illegitimate—total: 10 (males 2: females 8)

Rate: 22.7 per 1,000 total (live and still) births.

Deaths

There was a slight fall in the total number of deaths to 7,422 although the number of deaths from cancer and other malignant diseases, and from diseases of the respiratory system other than tuberculosis, both showed some increase. A summary of the causes of death is given below, and more detailed breakdown being given in tables and in the Appendix.

Causes of Death

Tuberculosis and other infectious diseases	..	..	..	..	103
Cancer and other malignant diseases	..	..	..	..	1,254
Vascular lesions of nervous system	..	..	..	..	1,157
Diseases of heart and circulatory system	..	..	..	..	2,977
Diseases of respiratory system (excluding tuberculosis)	..	..	..	..	696
Diseases of stomach and digestive system	..	..	..	..	80
Diseases of genito-urinary system	..	..	..	..	149
Maternal deaths	..	..	..	..	3
Accident, suicide, etc.	..	..	..	..	267
All other causes	..	..	..	..	736

TOTAL DEATHS 7,422

INFECTIOUS DISEASES AND THEIR CONTROL

Notification of Infectious Diseases

The following cases of infectious diseases were notified during the year:—

Measles	4,550	Dysentery	67
Whooping Cough ..	1,301	Food Poisoning ..	49
Tuberculosis	317	Typhoid and para-typhoid ..	12
Pneumonia	307	Puerperal pyrexia	10
Scarlet Fever	169	Ophthalmia neonatorum ..	2
Polioomyelitis	25	Diphtheria	2

Measles

Most of the cases of measles occurred during the first quarter and represented the tail end of the epidemic, which occurred during the winter 1955/56

Whooping Cough

There were nearly twice as many cases as last year, with a particularly heavy incidence in the Plympton area.

Tuberculosis

Owing to its importance, this is again dealt with in a separate chapter.

Polioomyelitis

Fortunately there were relatively few cases this year —25 against the 74 notified in 1955. Of these 17 were paralytic and 8 non-paralytic. The majority of these cases occurred in the Torbay area and surrounding districts.

Typhoid and Para-typhoid

This year there were 3 notified cases of typhoid and 9 of para-typhoid. 2 of the cases of typhoid occurred in cousins living in the same village, but who were not in contact with one another so far as could be traced. The source of infection was not determined, although investigations with sewer swabs undertaken by the district Medical Officer of Health in conjunction with Dr. Moore of the Public Health Laboratory Service did lead to the detection of a typhoid carrier in the community. He had no direct contact, however, with either of the cases. The third case of typhoid occurred in an elderly man living alone in North Devon. He obtained his water supply from a hillside spring, but tests of the water proved satisfactory and the source of his infection was not traced either.

7 of the 9 cases of para-typhoid were accounted for by a small outbreak at a service camp, and investigations brought to light a carrier of para-typhoid organisms amongst the personnel at the camp.

Dysentery and Food Poisoning

The number of cases of dysentery was about the same as last year, but slightly fewer cases of food poisoning were notified. Of particular interest is an outbreak which occurred at a school in North Devon. 16 out of 32 children who had taken the school lunch at the first sitting were suddenly taken ill with profuse vomiting about three hours later. A member of the staff also had lunch at the first sitting, and noticed a bad taste associated with the tinned peas. Because of this no peas were served to children at the second sitting, and there were no cases amongst these children. Investigations suggested that at least one of the tins used had been "blown," and subsequent examination of supplies in other parts of the area revealed a few other "blown" tins and that others were badly rusted or damaged. Bacteriological investigations showed that staphylococcus aureus was present in the sample of peas obtained from the canteen. Other tins subsequently brought in for examination yielded growths of lacto bacilli and large numbers of a green streptococcus.

Two days later a similar outbreak was reported at a Holiday Camp in the same area, affecting a total of 45 people. Tinned peas from the same manufacturer were incriminated in this outbreak also, and the necessary steps were taken for appropriate investigations and action at the canning factory in another part of the country.

Diphtheria

This year 2 cases of diphtheria were notified. The infection was brought into the country by a man who returned from abroad with an unusual form of diphtheria of the skin. His daughter, aged 4, who had not been immunised, developed a fairly severe diphtheria but fortunately recovered. Her brother had been immunised and did not develop the disease.

Vaccination and Immunisation

Smallpox Vaccination

There was a welcome increase in the number of primary vaccinations carried out this year, although most of this increase was in respect of children over the age of one year. The proportion of babies vaccinated during their first year of life remains at about 30%

	<i>Primary Vaccinations</i>			<i>Re-vaccinations</i>
	<i>under 1 year</i>	<i>over 1 year</i>	<i>Total</i>	
Undertaken by A.C.M.Os.	468	357	825	3
Undertaken by G.Ps.	1,601	2,063	3,664	1,484
Total	2,069	2,420	4,489	1,487

Diphtheria Immunisation

The cases of diphtheria mentioned above emphasized the point I made last year that our immunisation programme must be maintained in order to prevent the return of this disease. The following table shows the number of courses of injections undertaken during the year:—

	<i>Primary Courses</i>			<i>“Booster” Injections</i>
	<i>Infants and Pre-School Children</i>	<i>School Children</i>	<i>Total</i>	
Undertaken by A.C.M.Os.	1,271	496	1,767	6,828
Undertaken by G.Ps.	3,643	194	3,837	736
Total	4,914	690	5,604	7,564

The following figures show the immunity index for children in various age groups:—

<i>Age on 31.12.56</i>	<i>Under 1</i>	<i>1—4</i>	<i>5—14</i>	<i>Under 15 Total</i>
Estimated mid-year child population	6,390	26,510	74,900	107,800
Immunity Index 100	14.72%	61.49%	64.95%	61.12%

The figure for the under ones is more than double last year's figure, due doubtless to some extent to the introduction of combined diphtheria and whooping cough immunisation, which protection has to be given earlier than that against diphtheria alone.

Whooping Cough Immunisation

During the year combined diphtheria/whooping cough immunisation was introduced, as forecast in my last report. Protection against both diseases is achieved by means of three injections of the combined prophylactic, which are given at monthly intervals starting preferably before the baby is three months old. Because of the reduction in death rates from other childhood infections, whooping cough is fast becoming relatively the most deadly of these diseases. It is hoped that the immunisation programme will prevent not only deaths of young children but also permanent lung damage, which can cripple a child even to the extent of making it necessary to send him to a residential school later. The majority of parents are aware of the benefits of whooping cough immunisation and are anxious to have its protection. Few, however, are conscious of the continued need for diphtheria immunisation, and the use of the combined vaccination will, we feel, help to keep up the level of protection against diphtheria also. The table below shows the number of children protected since the scheme was introduced on the 1st April.

	<i>Primary Courses</i>		
	<i>Pre-School Children</i>	<i>School Children</i>	<i>Total</i>
Undertaken by A.C.M.O.s.	1,015	292	1,307
Undertaken by G.P.s.	2,842	135	2,977
Total	3,857	427	4,284

Poliomyelitis Vaccination

Another important development during 1956 was the introduction of a British poliomyelitis vaccine. Parents of children born in the years 1947—1954 inclusive were invited to register their children for vaccination. Of approximately 50,000 children in the eligible group, some 17,131 were registered before the closing date on 31st March. It was realized that sufficient vaccine would not be available to protect all these children during the year, and a selection was made at national level according to the month and year of birth. The children chosen for vaccination were those born in November of any of the years 1947—1954, or in March of the years 1951—1954, together with a few children born in August 1947—1954. 1,441 children received the course of two injections during May and June. By the time vaccination was suspended for the summer, there were 129 children who had received only one injection, and of these 106 received the second injection during November.



Photo by courtesy of the North Devon Journal—Herald

FIRST POLIOMYELITIS VACCINATION

Owing to the stringent requirements for storage of vaccine at temperatures between 0°—4°C., and the fact that in some of the more rural parts of the County not more than two or three children could conveniently come to one centre to receive injections, the amount of time and effort spent was wholly disproportionate to the number of children who received the injections. It is hoped that we shall have greater freedom in making arrangements for the very larger number of children we expect to be able to protect next year.

B.C.G. Vaccination

Early in the year the Medical Research Council published an interim report on the trials undertaken on school leavers in certain areas of the country, and subsequently the Ministry of Health published Circular 14/56 inviting those Authorities who had not yet decided to adopt the scheme of B.C.G. vaccination to re-consider their decision. Our original decision not to adopt the scheme had been taken after thorough discussion at one of the Chest Physicians' Conferences, when it was felt that a greater contribution to the control of tuberculosis in Devon would be made by using available man power and resources in the tuberculin testing scheme for school children (see page 19). It was, of course, also felt advisable to await the findings of the M.R.C. trials.

The Committee decided in the light of the M.R.C. report to agree in principle to the introduction of the scheme, although it was not possible to bring it into operation during the year because our efforts were diverted to deal with the poliomyelitis vaccinations.

TUBERCULOSIS

Tuberculosis Control is the Joint Responsibility of the Regional Hospital Board and the Health Committee of the County Council, the former being responsible, in the main part, for Diagnosis and Treatment, and the latter for Prevention, Care and After-Care. Co-ordination of day to day work is maintained through the four Chest Clinics at Barnstaple, Exeter, Plymouth and Torquay, the Chest Physician in charge of each being a part-time officer of each of the two bodies.

Overall direction of policy is maintained through an Annual Conference, and attended by certain Medical Officers of Health, the Consultant Chest Physicians from the Exeter and Plymouth Clinical Areas and the four Area Chest Physicians, the Directors of Mass Radiography, and an observer from the Ministry of Health. This year we were pleased to welcome Dr. Eley to our Conference.

The main hospital service for treatment of respiratory tuberculosis is at Hawkmoor Chest Hospital, and there are also beds at

Hawley, Whipton Isolation Hospital and in the Plymouth area. Beds for children are available at Honeylands and Rosehill. Orthopaedic cases are treated at the Princess Elizabeth Orthopaedic Hospital and many other forms of tuberculosis at the General Hospitals in this County.

The Mass Radiography Units are centred at Devonport and one unit is shared by the County Area and the City of Exeter.

Care and After-Care Services function mainly through the Health Visitors who are especially seconded for work at each of the four Chest Clinics.

Chest Clinics

The work of the four Chest Clinics in Torquay, Barnstaple, Exeter and Plymouth is summarised in the table below.

Chest Clinic Statistics—1956

	<i>Torquay</i>	<i>B'stple</i>	<i>Exeter</i>	<i>Plymouth</i>	<i>Total</i>
Patients on Register 1.1.56	137	850	1,049	458	3,494
New Notifications	147	49	105	41	337
Deaths	27	15	22	10	74
Patients on Register 31.12.56	1,181	849	1,071	481	3,582
First examination of suspects	1,030	695	974	393	3,092
Cases of T.B. found	129	33	36	38	236
Contacts examined	517	253	379	1,124	2,273
Cases of T.B. found	6	Nil	8	2	16
Contacts vaccinated with B.C.G.	104	30	145	113	392

The following analysis of the source of referral of the newly detected cases is of interest, showing as it does that the majority are referred by their own doctors because of cough or other suspicious symptoms. Cases picked up as a result of the tuberculin testing scheme of school children will be included in those referred from Mass Radiography Units. Some may have come via general practitioners if the parents anticipated the visit of the Unit.

Source of Referral of Newly Discovered Cases

	<i>Torquay</i>	<i>B'stple</i>	<i>Exeter</i>	<i>Plymouth</i>	<i>Total</i>
General Practitioner		44	50	29	123
Mass Radiography	not	2	11	9	22
Contact examinations	available	1	12	2	15
Other hospitals		—	32	—	32
Services		2	—	1	3

Dr. McMillan reports:—

“ During the year plans for the new Chest Clinic at Barnstaple materialised after much putting pencil to paper owing to the necessity of trying to put a quart into a pint bottle by compressing the Clinic into an existing stores building 48ft. x 22ft. The actual building was commenced in December, 1955. The finished Clinic however, apart from the somewhat restricted space is well planned, and contains such refinements as blower and exhaust fans in the treatment and consulting rooms, steam-heating and a Roneo equipped Record room

A striking reduction in the number of new Artificial Pneumothorax cases attending the refill clinics has been noted, showing that this form of treatment has largely been replaced by Anti-biotic and Chemotherapy.”

Dr. Mellor also comments on the effect of chemotherapy.

“ Active treatment—artificial pneumothorax and pneumoperitoneum—continues but is on the wane and it is anticipated that within the next two years refill clinics as such will no longer exist.”

He continues:—

“ There was an overall slight increase on previous years in the number of cases attending the clinics. More non-tuberculous cases are being referred for opinion and treatment than previously.” Dr. Midgley also refers to the “ evidence of continued growth of clinic work both because the T.B. registers continue to increase and the doctors are referring more non-tuberculous cases. . . . In fact the Service has developed into a consultative one for respiratory disease in general.”

Posthumous Notifications Dr. Midgley reports:

“ According to the records 17 persons had tuberculosis mentioned on their death certificates, and were thought not to have been notified during life.

Investigation into these cases has shown that 5 had been notified (dates verified). Of the remaining 12 cases, 4 were known

to the chest clinic and were not considered to have active tuberculosis. In all these cases, however, appropriate action in regard to contacts and supervision had been taken.

Of the remaining 8 cases:

- 1 was a known case who died in a mental hospital, but had not been notified
- 1 was only diagnosed by a positive sputum culture received four weeks after death.
- 1 collapsed in the street from heart failure. Coroner's post mortem revealed advanced pulmonary tuberculosis.
- 4 died in hospital from tuberculous meningitis, miliary tuberculosis, diabetic coma complicated by tuberculous empyema, and tuberculosis of suprarenals respectively. Post-mortem diagnosis in every case.
- 1 died from uraemia secondary to long-standing kidney disease presumed to be tuberculous.

Appropriate action in regard to contacts was taken in all but one of these cases. The exception was one in which the contacts were un-cooperative."

Chest Hospitals

Dr. Midgley has also submitted the following report on hospital treatment.

"Although the number of patients admitted to our hospitals by reason of tuberculosis remains about the same as last year (558 in 1956, 562 in 1955) the average length of stay has been shorter (143 days in 1956, 154 days in 1955). This reduced demand for beds for tuberculous patients has made it possible to discontinue using the twelve chalets at Hawley, and to relinquish the ward which had been made over to us in the Torquay Isolation Hospital.

An investigation into the merits of bronchial lavage as a means of recovering tubercle bacilli from sputum-free patients was made in Hawkmoor. It was found to be superior to gastric lavage and has now replaced it as a routine method of diagnosis. Over a hundred tests were also carried out on volunteers from among the nursing staff, partly as a control series and partly as an attempt to estimate the normal risks of nursing in the tuberculosis wards. The tests were made immediately after bed-making which was considered to be a period of maximum risk. In no case were tubercle bacilli recovered, a result which is most gratifying.

A start has been made on the development of a Department of Respiratory Physiology. This was rendered possible by a gift of

money from a wellwisher, supplemented from the Free Monies. Dr. G. F. Trobridge was entirely responsible for the design and construction of the apparatus, which is proving a great benefit to the general work of the hospital."

Domiciliary Care and After Care

During the year the District Nurses have continued to visit tuberculous cases being nursed in their own homes and to assist them in any way possible.

The Health Visitors continue to maintain close liaison with the Chest Physicians and help to deal with the many problems of the families of tuberculous patients. During the year the Health Visitors paid 1,846 visits to homes of tuberculous patients.

Extra Nourishment

It is the policy of the Council to issue two pints of free milk per day to each patient who would benefit by this milk and recommended by the Chest Physician.

Rehabilitation

At the beginning of the year the Council was maintaining one female patient at Papworth Village Settlement, Cambridge, and two male patients at British Legion Village in Maidstone. One male patient at Enham-Alamein, who has been there since January, 1955, was colonised in August and I understand he is making very satisfactory progress. One of the patients at the British Legion Village was discharged in November, 1956, after taking a course in clerical work and accountancy, and has now found employment in a hotel in Devon.

Spero Holidays

The National Association for the Prevention of Tuberculosis has recently started a scheme called the "Spero Holiday Scheme" because in the past, tuberculous patients have found a reluctance by landladies at holiday resorts to accept them when they heard of their illness. The Spero Scheme find accommodation where these patients would be welcome and makes all the arrangements. During the year, the County Council agreed to implement this scheme and to contribute towards the expenses according to an income scale. The first patient went to Ventnor in the Isle of Wight for two weeks holiday, which she thoroughly appreciated. The Chest Physician has reported that she had put on weight and benefited from her stay.

Occupational Therapy

During the year there was a small overall increase in the total number of cases referred and visited, but this was mainly accounted for by cases other than tuberculosis.

At the beginning of the year we were fortunate in having a full complement of therapists, but this happy state only lasted until July, when one of our therapists left; to date we have been unable to find a successor. The shortage of staff meant that the pressure on the remaining therapists was considerably increased.

The range of craftwork has remained the same, but there is more woodwork and plaster work being executed. It has been found that, in view of the costs, there is little demand for the purely decorative crafts except in a locality where they can be sold. We are investigating the possibility of starting shoe repairing instruction on a small scale in the near future.

The disposal of goods produced remains a difficulty, and in some areas therapy has been refused because of the cost to the patient who often has no outlet for his work. Whilst the therapists are doing all they can to help in this matter, they have not at present the time to act as sales agents.

Prevention

With tuberculosis it is impossible to differentiate prevention from treatment. For example prompt hospitalisation and treatment of a sputum positive patient will help to prevent further spread of the infection. Examination of contacts of known cases helps in early diagnosis and thus prompt treatment. Detection of a case by mass radiography or via the tuberculin testing scheme, at an early stage before the condition becomes infective plays an even greater part in prevention.

Last but not least come measures to increase the resistance of the individual to the germ—protection by B.C.G. Vaccination.

Great progress is also being made in eradication of bovine tuberculosis and by extending designated areas in which only T.T. or pasteurised milk may be sold. This should result in an even further fall in the numbers of cases of non-pulmonary tuberculosis especially in children.

Contact Examinations

Some Chest Physicians have drawn attention to a relatively poor yield of contact examinations. Thus of 1,377 contacts examined in two areas, only 2 were found to be suffering from tuberculosis—an incidence not substantially greater than that found in the general public by the Mass X-Ray units. In the other two areas, however, 896 examinations yielded 14 cases—surely a worthwhile yield of 15.6 per thousand.

It is difficult to say by how much the figures could be improved had we an adequate number of Health Visitors in all areas to find and to persuade all contacts to attend for examination.

Mass Radiography

Dr. Hollis reports as follows:—

During 1956 31,561 Miniature Film examinations were carried out in the County of Devon, 29,714 by the Unit 10E (Dr. Hollis) and 1,847 by Unit 10C (Dr. Sheers). Numbers of Devon residents were also X-rayed during the periodic visits of the Units to Exeter and Plymouth. Full statistics of the work carried out are given in the appendix.

36 Active cases of Tuberculosis, and 222 cases requiring further observation were found. The incidence of 1.14 Active cases per thousand is lower than the figure given for 1955, and in part reflects the decreasing incidence of the disease. In part, however, it is felt that the decreased yield is due to the increased number of repeat examinations carried out. It is therefore the aim of the service to seek out persons who have not been examined recently. Hence the policy of more thorough, but less frequent surveys is being adopted increasingly. In addition, regular routine visits to selected centres are planned for the examination of special groups. These special groups include high yield sections such as Mental Hospital populations, General Practitioner cases, and Contacts as well as numbers for whom routine radiography is specially indicated such as Hospitals Staff, School Leavers, and persons in contact with children. Once again, priority has been given to schools and institutions where a recent case of tuberculosis has been found.

During the years 1955 and 1956, the Unit has been based at Plymouth, and the considerable volume of work in Devon has hence been carried out at much geographical disadvantage. During 1957, it is hoped to move the base to Exeter, which will both improve the service it is possible to give, and ease the heavy burden imposed on the staff. It is also hoped that during 1957 the department may be able to acquire a light mobile unit, some of whose service will be given to the County of Devon. This will enable some of the smaller centres, which have not yet been visited, to be economically surveyed.

The changing character of the Tuberculosis scene necessitates an arduous hunt for the decreasing, but important unknown cases, if we are to conquer this disease. Such a programme needs much close co-operation and assistance from the County Medical Department, and the Chest Clinics if it is to be effective. This is forthcoming in full measure in Devon."

Tuberculin Testing Scheme.

This scheme commenced in September 1954 when children first entering County Primary Schools at the age of 5 years were all "jelly" tested. When a child gave a positive reaction all other children in the family were given a "jelly" test and the positive reactors together with all adults in the family, were offered an appointment at the Mass X-Ray Unit on its next visit.

In September, 1955, the new entrants were also included, and the previous years' entrants (now aged 6 years) were retested. In the latter case action was only taken where a child had "converted" and become tuberculin positive during the year. Such children are being referred to Chest Clinics for observation since it is felt that conversion implies a recent exposure to infection, but in addition adults and tuberculin positive siblings are being X-Rayed by the Mass X-Ray Units.

Figures are now available for the first two years of the scheme although still not complete since some children and "contacts" picked up late in the school year 1955/56 are under observation and no diagnosis has yet been made.

	1954/55	1955/56	Total
No. of children tested on entry at 5 years.	5,938	4,794	10,732
No. positive	404 (6.8%)	206 (4.3%)	610 (5.7%)
No. of positive children X-rayed	284 (70%)	168 (70%)	452
No. of children re-tested at 6 years+	Nil	3,541	3,541
No. again positive on re-test	Nil	130	130
No. of "convertors"	Nil	36 (1%)	36
No. of contacts listed of children positive on first test or of convertors.	1,087 (2.6 per child)	*749 (3.1 per child)	1,836
No. of contacts known to have been X-rayed.	335 (30%)	*353 (47%)	688

* Figures not yet complete.

So far the following cases have been detected by the Scheme.

(a) *Amongst Tuberculin positive children*

3 children with primary tuberculosis (in one case an aunt had had the disease but surveillance had been discontinued).

2 children with tuberculous cervical glands.

1 child with a congenital lesion of the heart.

3 children with pulmonary lesions other than tuberculosis.

18 children are still under observation.

(b) *Amongst family contacts*

2 mothers with pulmonary tuberculosis (1 active, 1 inactive)

1 brother aged 2 with primary tuberculosis.

2 mothers are under observation (one was an old case of tuberculosis not notified to us when she moved to Devon).

2 brothers are under observation.

In addition to the above the scheme picked out the following cases which were already known to one or other of the Chest Physicians.

1 child with primary tubercle.

1 child with T.B. glands.

2 children and 1 contact requiring observation.

The results of the first two years of the scheme are to some extent re-assuring but, at first glance, also slightly disappointing. It is good to know that today only about 5% of children have come in contact with tuberculosis germs by the time they enter school. It will be remembered that at the time of the special survey made in one area of the county in 1949 for the Medical Research Council as many as 22.9% of 5 year olds were Mantoux positive.

It was a little disappointing to find that in the first year apparently only about a third of the contacts were attending for X-Rays. Careful enquiry revealed that in fact many more had been X-rayed. Some had attended public sessions of the Mass X-Ray but had not handed in the special appointment slip: we had not therefore been apprised of the results: others had been worried, had not awaited the visit of the X-Ray Unit and had gone to their family doctor who referred them to hospital for X-Ray—and again without any report coming to us.

Next year the tests will no longer be linked with School Medical inspections but will instead be timed to take place shortly before the visit of the Unit so that delay will not cause undue worry (and referral to hospital by the family doctor) or conversely allow apathy to develop. The Health Visitors will stress too the importance of handing in the special slips.

A decision was also made to replace the jelly test by Heaf test next year. This will be less time consuming for the Health Visitor

to apply and should avoid a proportion of false positives we have undoubtedly been encountering and thus leading to unproductive effort.

B.C.G. Vaccination

Chest Physicians vaccinated with B.C.G. 392 direct contacts of known cases of tuberculosis during the year. As already mentioned a scheme for routine B.C.G. vaccination of 13 year old school children was agreed in principle and will come into operation next year.

FOOD AND MILK—WATER AND SEWAGE

The County Public Health Inspector submits the following report for 1956:—

Food and Drugs Act, 1955.

During the year 2,482 formal and informal samples were taken by the seven Sampling Officers employed in the Department. 959 of them were submitted to the Public Analyst and the remainder (all milks) were examined by the Gerber Test in the laboratory attached to the Department. Of the 959 samples, 274 were of milk and 685 were of commodities other than milk.

The samples submitted to the Public Analyst represented a very wide range of foodstuffs and medicines—milk, ice cream, sausages, spirits, proprietary medicines and drugs, to mention only a few of the commodities given special attention.

The Public Analyst reported that 98 samples were either adulterated or gave rise to some other irregularity. 86 of the 98 were samples of milk and 38 of these contained added water. As a result, 9 vendors were prosecuted and warning letters were sent in 7 other cases.

24 samples of milk were ones in which the non-fatty solids and/or butter fat was below the normal accepted figures, but investigation in each case showed that the milk was being sold in the same condition as it came from the cow, so that no offence under the Food & Drugs Act was being committed.

The remaining samples reported on by the Public Analyst were commodities other than milk; 2 were diluted spirits and a prosecution was successfully instituted in each case. The remaining 10 samples were of bread and butter, rum and butter confectionery, sago, pineapple, dyspepsia tablets, buttered roll, milk chocolate mallow creams, a chemical food, coffee creams, and Glaubers Salt.

The Sampling Officers take their samples with considerable care and selectivity. Apart from the help given in this Department,

they are assisted and advised in their choice of samples by consultation with the Public Analyst, a close study of the reports issued by the Public analysts of other Counties and public accounts of the legal action taken by other Food & Drugs Authorities.

Milk and Dairies Regulations, 1949

The Milk (Special Designation) (Pasteurised and Sterilised Milk) Regulations, 1949.

The County Council issued licences to the 12 Pasteurising operators in the County and a very careful watch is kept both on the Pasteurising Plants and the processed milk. This involves regular inspections and samples are submitted for laboratory examination at very frequent intervals. Additional checks on the quality of the processed milk are afforded by the routine sampling of milk supplied to schools in the County. A very large proportion of the school milk is derived from these plants.

Milk in School Scheme

The tendering and three-year contract system of supplying the schools with milk commenced in 1955 has worked with great success as far as this Department is concerned. Of the 610 schools of all types, 581 take Pasteurised milk derived from only 9 Pasteurising establishments. This has enabled effective supervision of the supply to be maintained, with a substantial reduction in the amount of work this had hitherto involved.

1,016 samples of Pasteurised milk were submitted for examination, and all but 4 passed the Phosphatase Test. 106 samples of Tuberculin Tested milk were also examined by the Methylene Blue Test.

Biological Examination of Milk for the Presence of Tuberculosis

During the year a total of 959 samples was submitted. Not a single sample was positive. This is the first year since sampling was instituted on its present level by the County Council in 1950 that this has occurred. The figures for preceding years are as follows:—

<i>Year</i>	<i>Samples</i>	<i>Positives</i>
1950	638	5
1951	726	2
1952	781	11
1953	475	3
1954	1028	12
1955	1041	5

The Milk (Special Designations) (Specified Areas) Orders:

A further area of the County was scheduled by the Ministries concerned to be one in which only Pasteurised, Sterilised or Tuberculin Tested milk could be sold by retail.

The specified area comprised the Borough of Tiverton and the Rural District of Tiverton

Approximately 63% of the population of the County is now covered by Specified Areas, but, in terms of acreage, only 37% of the County's area is covered. The explanation is that the areas so far declared are in the southern half of the County, with its greater density of population.

It is not known when the remainder of the County will be specified, but there is reason to hope that this will be done certainly within the next five years. This gradual reduction of the sale of Ungraded Milk to the public is welcomed as a great step forward in the prevention of milk-borne infections.

Rural Water Supplies and Sewerage Acts

The three Water Boards—the North Devon, the South Devon and the East Devon Water Boards—have all been active during the year, despite restrictions, and all have substantial schemes, either in course of construction or awaiting the consent of the Minister of Housing and Local Government. This progress is emphasised by the increasing amount of the precept which each Board makes on the County Council. Comparative figures are as follows:—

	1954/55:	1955/56:	1956/57:	1957/58:
	<i>Actual Cost</i>	<i>Actual Cost</i>	<i>Actual Cost</i>	<i>Precept</i>
<i>North Devon Water Board:</i>	£68,323	£82,587	£111,350	£96,000
<i>South Devon Water Board:</i>	£40,086	£44,505	£50,800	£85,000
<i>East Devon Water Board:</i>	£18,788	£23,037	£24,950	£35,000

The great progress made with the provision of sewerage and sewage disposal facilities in the County up to the end of 1955 continued during the year at a somewhat lower level. This was due to the effects of the Government decision limiting capital expenditure, which at first threatened to prevent any new schemes starting at all. As the year wore on, however, it became apparent that a number of much needed schemes were being allowed to proceed.

During the year, the following schemes were considered by the County Medical Department, and recommendations in each case were made to the appropriate Committee of the County Council:—

Water Supply Schemes

<i>Local Authority:</i>	<i>Parishes or Areas Affected:</i>	<i>Estimated Cost:</i> £
Newton Abbot R.D.	Bovey Tracey	1,170
St. Thomas R.D.	Bridford and Christow	2,900
	East Budleigh	750
	Ashton	2,205
	Bridford	1,075
	Clyst St. George	1,050
	East Budleigh (Ting Tong)	4,250
	Ebford	1,250
	Powderham	12,000
	Mamhead	2,650
	Woodbury	1,025

Sewerage and Sewage Disposal Schemes

Ashburton and Buckfastleigh	Joint Scheme	106,000
Axminster R.D.	Axminster	6,398
	Hawkchurch	11,182
Barnstaple R.D.	Braunton, Saunton, Knowle, etc.	175,778
	Instow	28,500
Bideford R.D.	Clovelly	18,300
Brixham U.D.		138,000
Kingsbridge R.D.	Chillington (revised)	15,445
	Kingston	17,600
Kingsbridge R.D.	Stokenham	12,429
	Stokenham (sewer extension)	1,730
Ottery St. Mary U.D.	King's School Area	7,850
	Tipton St. John	21,770
St. Thomas R.D.	Clyst Valley (revised)	286,000
	Bramford Speke (revised)	19,950
	Pinhoe	2,450
	Starcross	1,250
Seaton U.D.		54,300
Tiverton R.D.	Bampton	650
Torrington R.D.	St. Giles-in the-Wood	10,850
	Kingscott	9,300
	Roborough	8,800
Totnes R.D.	Churston Ferrers	2,480

Ministry Inquiries, Visits of Inspection

This Department has represented the County Council at each of the 21 Ministry of Housing and Local Government Inquiries and Visits of Inspection made in connection with sewage disposal and water supply schemes, and the County Public Health Inspector has given evidence in all cases.

PERSONAL HEALTH SERVICES

MATERNITY SERVICES

The drop in the total number of births recorded in the previous year has been arrested and there has been a small but definite upward trend. For the first time domiciliary confinements have been less than 40%. This appears to confirm the tendency for women nowadays to seek an institutional confinement rather than to have their babies in their own homes.

Under Section 203(2) of the Public Health Act, 1936, all births in the Administrative County must be notified within 36 hours to the County Medical Officer.

39.3% of infants were born at home and 60.7% in hospitals or other institutions.

In the County 6,685 live births were notified (adjusted for transfers in and out).

Domiciliary	2,628
Institutional	4,057
Total	<hr/> 6,685 <hr/>

Stillbirths

In the Administrative County, 157 stillbirths were notified during the year (adjusted for inward and outward transfers.)

Domiciliary	47
Institutional	110
Total	<hr/> 157 <hr/>

The proportionate loss of infant life before or during the process of birth remains unchanged.

Neonatal 1st week

80 notifications of death within the first week of life were received. Thus the peri-natal death rate was 34.6 per thousand births.

Midwifery

The Domiciliary Midwifery Service has again been well used, 2,599 births having been attended this year. There are 9 full time midwives and 145 who combine midwifery with general nursing duties.

The Midwife-Health Visitor Ante-Natal Clinics continue to flourish and have expanded to 16. Teaching in these Clinics has come to be expected by the mothers and additions to the teaching

aids have been made. Amongst these aids, many midwives find the record player film strip a great help towards discussions.

Results of the use of oxygen for resuscitation of small or premature babies or full-time babies suffering difficult births, has been most gratifying. It has been used for 42 infants, 38 with excellent results, and the midwives concerned feel that it was a life saving measure in seven cases.

Similarly, Intra-Gastric Oxygen has been given in 19 cases and so far as can be estimated at present, 8 of the small or premature babies and 5 of the full time babies are progressing satisfactorily and showing normal development.

Four letters of appreciation have also been received stating that parents and doctors are impressed and appreciate the facilities available for home confinements. Fathers particularly have shown tremendous interest and appreciation. Midwives who have not yet had the need to use Oxygen express their thanks for the apparatus, and say how much more confident they feel knowing that Oxygen is available if required.

27 Midwives have attended Post Graduate courses approved by the Central Midwives Board, in various parts of the country. The increased number sent this year was necessary in order that every midwife employed shall have attended such a course within the last five years by January 1958, this being a statutory requirement of the Central Midwives Board.

Through the local branches of the Royal College of Midwives, Study Days, lectures and demonstrations have been organised again this year and have been well attended. This is a most valuable way of keeping the domiciliary midwife up to date between her Post Graduate courses, and I am most grateful to the lecturers who undertake this work.

Ante-Natal Clinics

Three more centres have been opened in the year where clinic premises are available. These clinics are clearly meeting a need when nearly one quarter of the expectant mothers make use of these facilities. There are still many areas of the County where there are no County Council premises, and doubtless if suitable premises were hired many more mothers would attend. In this connection from time to time enquiries are received regarding the facilities for classes in instruction in natural childbirth.

The clinics are now held in 16 Centres, the total attendance during the year being:—

<i>Sessions</i>	<i>No. of Women Attending</i>	<i>No. of Attendances</i>	<i>No. of New Cases</i>
667	1,549	6,507	1,192

Family Planning

A grant is made to the Women's Welfare Association and to branches of the Family Planning Association running clinics accessible to married women resident in the County. The number of cases seen under the Devon County Council's arrangements was 91 new cases and 841 continuation cases, as compared with 134 and 734 in 1955.

Care of Unmarried Mothers and their Children

Unmarried mothers and their children are cared for by arrangement with the Diocesan Council for Moral Welfare Work, to whom a grant is made by the County Council, who, in addition, pay travelling expenses of workers engaged on cases referred by the County Medical Department.

During the year the Council dealt with 291 cases, 92 of which were referred to the Moral Welfare Workers by my Department. The County Council accepted financial responsibility for the following cases which were admitted to Mother and Baby Homes during 1956.

Dunmore, Bradninch	..	8
St. Olave's, Exeter	..	14
Southview, Plymouth	..	15
Others (outside		
County Boundary)	..	5
St. Nicholas, Exeter	..	17
		—
		59
		—

The greater number of admissions to Mother and Baby Homes is largely due to an increasing number of expectant mothers still under twenty years of age.

INFANT WELFARE SERVICES

The births of all infants are notified to the County Medical Officer under the Public Health Act 1936 and this information is passed to the Health Visitor for the area, who is supplied with a card for record purposes. She then visits the home of the baby between two or three weeks after the birth to offer the mother any advice and guidance she may wish for in the upbringing of the young family. In this County it is very rare for the Health Visitor to be other than welcome.

Premature Births

During the year 374 premature births (i.e. babies weighing 5½lbs. or less at birth, irrespective of period of gestation), were notified.

Table 3 (see page 78) gives the birth weight, place of birth and the number of premature babies surviving in each group at the end of 28 days.

Child Welfare Centres

The Child Welfare Centres continue to be popular with the mothers, in fact a section of the public do from time to time ask for increased and improved facilities. Each new generation of mothers appears to find its need for experienced help and guidance in the upbringing of young children materially helped by the staff of these Centres. The ready availability of vaccination and immunisation is another important aspect of the service of the Child Welfare Centres. Additionally, it is hoped that as staffing numbers improve steps can be taken to encourage an increased attendance by the pre-school child so that early troubles may be diagnosed and treated before school entry.

A new centre was opened at Sticklepath, Barnstaple. Attendances recorded during the year at the 79 centres were as follows:—

	<i>Totals</i>
Sessions held	2,827
Attendances by mothers	66,619
Infants attending (born in 1956)	3,216
Attendances by infants under 1 year ..	46,690
Children 1—2 years attending (born 1955)	3,033
Attendances by children aged 1—2 years ..	14,720
Children 2—5 years attending (1950-54) ..	5,111
Attendances by children aged 2-5 years ..	17,845

Welfare Foods

The distribution of Welfare Foods throughout the County continued to run along smoothly and efficiently, thanks to the organisation of the W.V.S. and to the many voluntary helpers partaking in this service.

During the year the uptake of National Dried Milk showed a decrease of 3.4% on the previous year, Cod Liver Oil a decrease of 8.2%, whilst A. & D. Vitamin tablets showed an increase of 8.7% and Orange Juice an increase of 11%.

240 voluntary distributors and the 44 W.V.S. operated centres have been responsible during the year for the issue of:

181,673 Tins of National Dried Milk
46,482 Bottles of Cod Liver Oil
18,150 Packets of A & D Vitamin Tablets, and
288,963 Bottles of Orange Juice.

Area offices are served by the staff of certain District Councils and by officers of the Childrens, Education and Welfare Departments of the County Council. One must record the unstinting help and co-operation received from them at all times.

Problem Families

The situation regarding these proportionately few families that give rise to special concern does not show much change. The number actually on the Register must tend to increase as so often several years of observation and help are necessary before a family is sufficiently rehabilitated to need no further special guidance. It is interesting to record that members of a few of these families have come to realise their need for assistance and will telephone or write for help and advice. On the other hand, some few families do break up and the children have to be received into care or placed with other relatives. The majority require continued special visiting, which in the main is carried out by the Health Visitor.

HEALTH VISITING SERVICE

Fixed appointments in schools and clinics are absorbing more and more of the Health Visitor's time leaving less time for visiting. In the little time that is available for visiting on the district the Health Visitor feels that she must see as many children as possible in the time at her disposal. In spite of this necessary pre-occupation with routine work, most Health Visitors are aware of the much wider field they should be covering.

Health Visitors have large areas and an increasing amount of work to cover. Anxiety is felt about the speed with which visits must be done so that very often an inadequate amount of time is spent with the mother and problems are thereby missed.

The particular fields where expansion is most essential are:—

(1) *Teaching of Positive Mental Health* and the early detection of signs of mental ill health or mal-adjustment. Much of this would be done in the course of routine visiting if the Health Visitor had sufficient time.

(2) *Health Education*. This should include group teaching, clinics, parent-teacher associations, old age pensioners clubs, voluntary organisations and in schools, co-operation with the preparation, and participation in the teaching, of health and parentcraft.

(3) *Care of the Aged*. Much more needs to be done to prevent unnecessary disabilities developing in the aged. The visiting of old people living alone and the giving of advice on general care, diet, care of the feet, etc. would be very valuable.

During the year a Superintendent Health Visitor was appointed and it is hoped that as a result of her work, there will be even greater harmony and closer co-operation between the members of the staff.

The most important event of the year was the publication of the report on the Working Party set up by the Ministry of Health, "Enquiry into Health Visiting." This report summarised the Health Visitor's duties as "Health education and social advice." It emphasised the importance of the Health Visitor as a general

purpose social worker and clarified the range of her duties. The report advocated the delegation to less highly skilled workers of routine jobs not requiring the full Health Visitor training. Suggestions were made with regard to training, improvement in conditions and salaries with a view to aiding recruitment.

A summary of the work undertaken by the Health Visitors during 1956 is as follows:—

<i>Type of Visit</i>	<i>No. of Visits</i>
Infants under 1 years	42,277
Children 1—2 years	20,486
Children 2—5 years	36,563
Expectant Mothers	3,200
Tuberculosis	1,845
Aged	2,259
Hospital after-care	390
Home Help Service	1,835
Under Children's Act	1,783
All Others	604
Attendances at Centres, Clinics etc.	5,729
" No Access " visits	9,663

HOME NURSING

The Home Nursing Service is carried out by 16 whole-time nurses, 1 of whom is a male nurse, and 145 nurses who combine general nursing with midwifery duties.

11 nurses have successfully undertaken Queen's Training for work in the County, and two nurses attended Post Graduate courses arranged by the Queen's Institute.

The District Nurse's work continues to be, in a large part, the care of the elderly and chronic sick—over 41 % of the cases attended were over 65 years old. However, the earlier discharge of patients from hospital gives the nurse more varied duties and she continues to work closely with the Health Visitors, Home Helps and her colleagues in the Welfare Department.

Additions to the nursing aids have been made amongst which foot rests, back rests, tripod walking sticks and portable commodes have been popular. The latter two aids have been of particular value in rehabilitation.

The projector and film strips have been in great demand again as the nurses have been asked to give talks to their local organisations including the British Red Cross, St. John's Ambulance Brigade, Women's Institutes and Youth Clubs. The record player film strips—a new addition this year—have been well used

The following table shows the main type of nursing undertaken by the Home Nurse:—

	<i>Medical</i>	<i>Sur- gical</i>	<i>Infec- tious Dis- eases</i>	<i>Tuber- culosis</i>	<i>Mater- nal Com- plica- tions</i>	<i>Others</i>	<i>Totals</i>	<i>Patients already inclu- ded who were 65 or over</i>	<i>Child- already inclu- ded who were under 5</i>
Number of cases attended	12,098	4,307	26	83	441	824	17,779	7,446	1,193
Number of visits paid	253,207	66,697	110	3,780	3,020	24,320	351,134	196,937	5,619

2,763 Patients received more than 24 visits during the year, the total visits to these cases were 80,916

Nurseries and Child-Minders Regulations Act, 1948

During the year one application was received for registration of premises as a Day Nursery for 20 children, and the number of Nurseries on the register at the end of the year was 3 providing for 82 children.

Three child-minders in the County are registered for 23 children.

Registration of Nursing Homes

Under Sections 187—194 of the Public Health Act, 1936, 3 Nursing Homes have been registered for 13 beds (medical convalescence), during the year. The total number of Homes on the register at the end of the year was 41, providing 69 maternity and 357 other beds. This excludes the Borough of Torquay to whom all functions under the above Sections were delegated.

Regular inspections are made of Nursing Homes for the purpose of ensuring that the byelaws made by the County Council under the Act have been duly observed.

Nurses Acts 1919—1945

Three applications for renewal of licences to carry on agencies for the supply of nurses, under these acts, were received during the year, and renewals granted.

HOME HELP SERVICE

During 1956 the W.V.S. took over the Service in Budleigh Salterton and Seaton and now operates in the following areas:

Axminster	Dawlish	Seaton
Barnstaple Urban/Rural	Exmouth	Sidmouth
Bideford	Ilfracombe	Tavistock
Brixham	Malborough/Salcombe	Teignmouth
Budleigh Salterton	Newton Abbot Urban/Rural	Tiverton
Crediton	Okehampton	Torquay
Dartmouth	Paignton	Totnes Borough/Rural

The remainder of the County is covered by application direct to the County Medical Officer and referred to the County Home Help Organiser, Health Visitors and District Nurses for supervision.

As at December 31st, 1956, 405 part-time Home Helps were employed and during the year the following 1,945 cases were dealt with:

	<i>Maternity</i>	<i>T.B.</i>	<i>Chronic Sick</i>	<i>Others</i>	<i>Totals</i>
W.V.S.	139	15	997	296	1,447
Other areas	111	10	261	116	498
	250	25	1,258	412	1,945

The trend continues for the greater part of the Service to be concerned with the care of old people in their own homes. In addition hospitals like to be sure of the provision of a Home Help in some instances before discharging a patient. The majority of such cases are of long duration, and the care of the aged in their own homes continues to be a major problem.

The demand for the Service has grown progressively during the past twelve months, and the numbers of cases dealt with above do not represent the total number of applications. In many cases patients have been given assistance to make their own private arrangements for domestic help, and the National Assistance Board have made supplementary grants to some cases where more economical facilities could be made use of outside the County Scheme. In such cases the need was adequately met.

My sincere thanks go once again to all the W.V.S. Organisers and their colleagues throughout the County for their splendid work in connection with the day to day running of the Home Help Service and for their co-operation with the Medical Department which has resulted, in spite of increased wages etc., in maintaining the Service at its present high level within the estimated expenditure.

MENTAL HEALTH SERVICES

Mental Defect

Many Mental Defectives live happily within the community. Many are recognised before the age of 5 and are supervised by the Health Visitors; those above 5 years of age are being examined earlier within their school careers by the School Psychological Service on request of the Head Teacher.

Those Mental Defectives whose behaviour necessitates their being restricted by operation of the Mental Deficiency Acts are often brought to our notice through various agencies, including Private Practitioners, Hospital Almoners, Probation Officers, National Assistance Board, Children's Officer, Health Visitors, School Nurses, parents and relatives.

Some children ascertained as Educationally Sub-normal are

eventually notified to the Mental Health Section of the Local Health Authority under the provisions) of Section 57(5) of the Education Act, 1944. These children are then either placed upon supervision after leaving school or not; sometimes the supervision can be changed to a Voluntary co-operation. Statutory Supervision debars the young Male from National Service Call-up, and with both sexes enables special allowances to be granted towards their upkeep. In addition it provides in the person of the "Supervisor" Social Worker in Mental Health, a Guide, Philosopher, and Friend.

Occupational Training

Some children who are excluded from school before school leaving age as being ineducable are offered training at Occupation Centres, if they are considered capable of benefitting by such training, or alternatively by lessons at home from the Home Teachers.

Devon County Council has three Occupation Centres at Barnstaple, Torquay and Plymstock. By arrangement seven children attend the Exeter Occupation Centre. The Somerset County Council takes a Devon child at their Occupation Centre near Ilminster by arrangement. All the Centres continue to do excellent work.

At Torquay an additional room has been re-decorated by the Torbay Society for the Mentally Handicapped. This Society has also helped to pay the cost of an escort for two children who attend the Centre.

In a scattered County like Devon the lack of travel facilities or a cripple state, or lack of escort or some such circumstance prevent many of the young adult defectives from collecting at Centres for daily instruction. There are Home Teachers in Mental Health to meet this emergency and at present they are three in number. Larger Group Classes have lately been gathered in Tavistock, Bideford and Sidmouth but these are often only possible by much hard work and arrangement on the part of the Home Teachers. There is still a vacancy for a Home Teacher, which fact denies tuition to about 30 outlying cases.

is still a vacancy for a Home Teacher, which fact denies tuition to about 30 outlying cases.

The Torquay Leisure Club for Adult Defectives of both sexes continues to do good work—this Club is held on Wednesdays from 2 to 5 p.m., at St. Luke's Church Hall, Torquay.

Guardianship

All cases under Guardianship in the County are visited by the County Psychiatrist at least once a year, or more if the circumstances warrant it. The Social Worker for the area also pays the required statutory visits i.e., once in six months, or more if necessary. They are active in helping the Royal Western Counties Institution, Starcross, to arrange holidays for those patients whose relatives have

asked for them by reporting and recommending the fitness of the home to receive the patient. There are many other supervisory calls made upon the Social Workers, including the undertaking of Guardianship.

General

The present policy of discharging patients after two years or less on Licence, and also the policy of transferring others to Guardianship is not only steadily increasing the amount of work of the Social workers but in many cases is presenting them with a type of case whose supervision presents difficulties, and takes up a good deal of time. This is particularly noticeable in the case of female defectives owing to the fact that of the same complement of Social Workers only two now are female as against four in 1950. A female Social Worker based in Barnstaple would be of great value.

The interpretation of the Law relating to Mental Defectiveness alters from time to time. It is now virtually impossible to remove defectives to a "Place of Safety" prior to the presentation of a Petition, however urgent may be the reasons for their removal. Logically, it is no longer possible to place patients under the Guardianship of their parents in their own homes.

MENTAL ILLNESS

All our ten Social Workers in Mental Health (2 women and 8 men) have Areas for which they are responsible for both statutory duties as Duly Authorised Officers and for Community Care. They work closely with the General Practitioner and Psychiatrist in an effort to create a well informed public opinion on the facilities which are now available in the field of mental illness.

They take a considerable number of patients directly to the Mental Hospitals and Out-patient Clinics for consultation or treatment. The Social Workers also prepare a detailed Social History on almost every patient referred. Under the guidance of the Psychiatrist, they will visit a patient on discharge from Hospital and report on his progress.

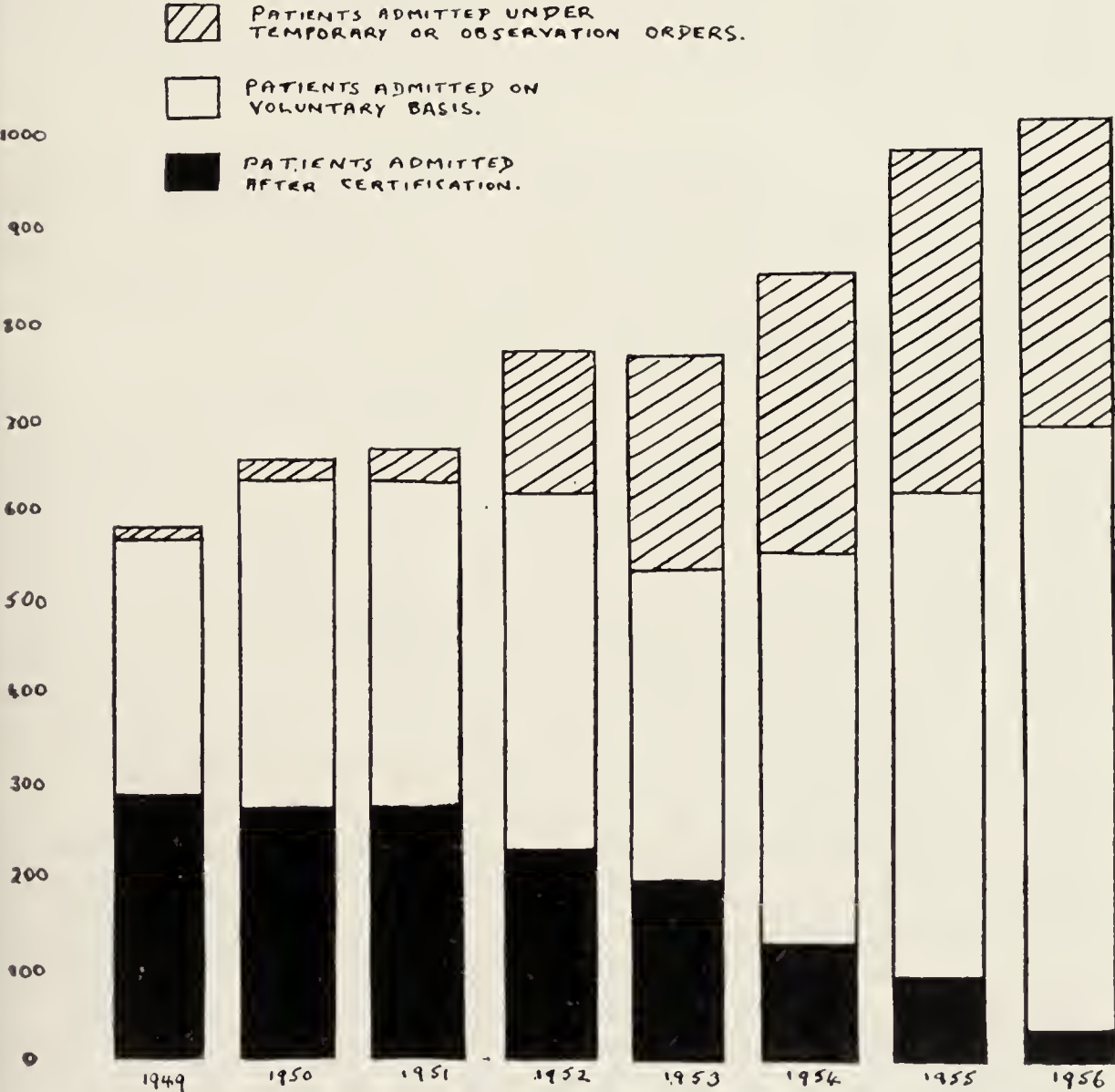
We welcome the opportunity of co-operating with other Statutory and Voluntary agencies towards ensuring the rehabilitation of the patient in the community. Early consultation, diagnosis and treatment of a mental illness is an important factor towards enabling a person to continue his normal activities and a most encouraging feature is that more patients are being referred by the family doctor to the Psychiatric Out-patient Clinics which are now established in General Hospitals at Axminster, Bideford, Exeter, Newton Abbot and Torquay. If special circumstances make it desirable, the Consultant Psychiatrist will visit the patient in his own home.

In the field of Mental Health generally, the knowledge, skills and

equipment now available for examination, diagnosis and treatment are much in advance of the present law. In fact, legal provisions enacted in 1870 and 1930 must still be used to meet the very different social conditions of today. It is appropriate that we draw special attention to the diagram on this page from which it will be seen that there has been a progressive decrease in Devon in the number of patients for whom admission to a Mental Hospital became necessary under Certificate. Conversely, there has been a noteworthy increase in the number of persons who have sought treatment as Voluntary patients. In addition, a very great proportion of persons admitted under Section 20, (for observation in hospital) improve so much that they become Voluntary Patients within a short time.

In large measure this may be a reflection of a healthier attitude, amongst the general public, who are now prepared to accept mental disorder as another "disease" which may affect a person just as any of the more obvious physical illnesses.

ADMISSIONS TO MENTAL HOSPITALS — DEVON 1949-1956



AMBULANCE SERVICE

	1955	1956	Comparison
<i>Ambulances</i>			
Journeys	31,273	31,571	+ 298
Patients	39,977	40,358	+ 381
Mileage	611,019	620,438	+ 9,419
<i>Hospital Cars</i>			
Journeys	44,843	47,067	+ 2,244
Patients	66,751	80,725	+ 13,974
Mileage	1,480,185	1,517,968	+ 37,783
<i>Hired Cars</i>			
Journeys	2,250	1,152	— 1,098
Patients	2,610	1,259	— 1,351
Mileage	21,087	10,716	— 10,371

The Year's Operations

The increase in the price of petrol will obviously mean an increase in the cost of the Ambulance Service. On the other hand, as a result of the petrol crisis, the Hospitals at Plymouth, Barnstaple, Exeter and Torquay have agreed to give twelve hours notice of the discharge of patients. This enables the Staff to co-ordinate journeys.

A modified form of Group Control has been in operation at Torquay since September, 1955. This scheme has been extended so that the following Stations are now linked with the Control at Torquay in order to bring about the mutual saving of journeys:—

Ashburton, Bovey Tracey, Newton Abbot, Brixham, Dawlish, Paignton, Teignmouth and Totnes.

Modified Group Control has also been introduced at Plympton where Tavistock, Plympton and Kingsbridge Stations have been linked with the Plymouth Ambulance Control, and at Barnstaple whereby all the Stations in North Devon co-ordinate their journeys through the Barnstaple Ambulance Station. A control system is also operated so that all ambulances arriving in Exeter report to the central office at Felixwell. Co-operation with the Exeter Ambulance Service then enables arrangements to be made for the ambulances, which would otherwise return empty, to take patients back with them.

The result has been an undoubted saving in the number of miles run. Unfortunately, this saving will not be reflected in the cost of the Service because of the increased cost of petrol.

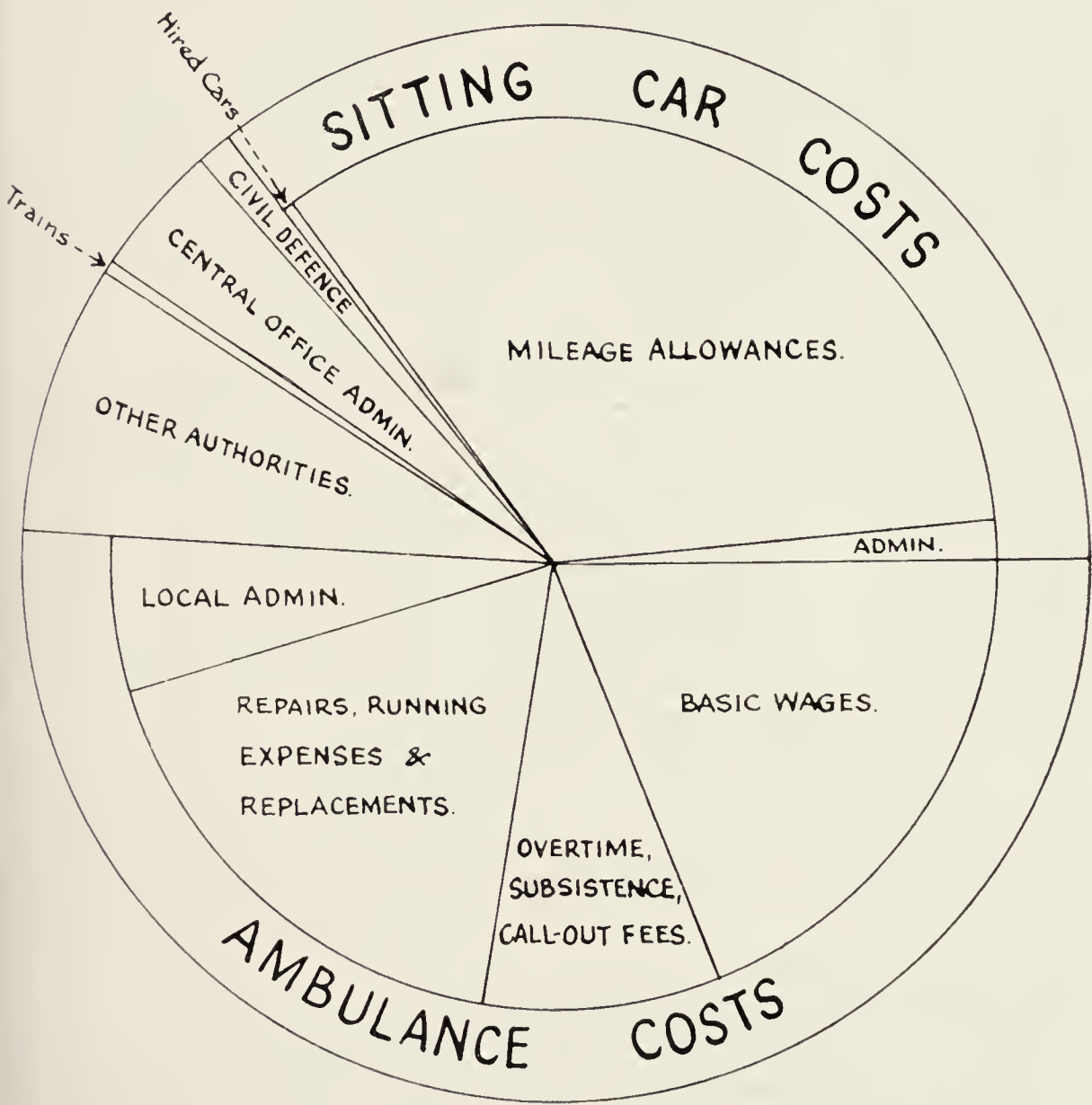
All these extra duties both at the Stations and at the central office have been undertaken without the need for additional staff.

Unfortunately, it seems inevitable that rises in the cost of petrol and wages will almost always outstrip economies made. These economies can never be made to the detriment of the patient. The first thoughts must always be the patient and no restriction

placed on the Service can be justified where the patient has to suffer in consequence.

Vehicles

Standardisation of the fleet is progressing by the purchase of more Morris L.D.1 type ambulances (16 horse-power) as replacements. Those vehicles are not only cheaper than the 28 horse-power vehicles previously purchased, but are also more economical to run.



SERVICES FOR THE AGED AND HANDICAPPED

Provision for the aged and handicapped under the National Assistance Act, 1948, is the responsibility of the Welfare Committee of the County Council. I am grateful for the following information supplied by Mr. G. R. Gay of the Welfare Department.

Residential Accommodation for the Aged, etc.

The County Council through the Welfare Committee provides residential accommodation in homes and hostels for persons who by reason of age, infirmity or other circumstances are in need of care

and attention not otherwise available to them. (This does not include *sick* persons in need of hospital treatment.)

Accommodation has been provided so far at the following:—

<i>Exmouth</i>	..	Kincraig, Cranford Avenue
<i>Exmouth</i>	..	Kingsdon, Douglas Avenue (Home for the Blind)
<i>Torquay</i>	..	Lincombe Court, Lincombe Hill Road
<i>Ashburton</i>	..	Kenwyn, Western Road
<i>Seaton</i>	..	White Cliff, Esplanade
<i>Kingsbridge</i>	..	Combe Royal
<i>Newton Abbot</i>	..	Broadlands, Ashburton Road
<i>Northam</i>	..	“ Fairlea ”
<i>South Brent</i>	..	Avondale House
<i>Okehampton</i>	..	Wardhayes
<i>Tiverton</i>	..	Alexandra Lodge
<i>South Molton</i>	..	Beech House
<i>Tavistock</i>	..	Gwynntor
<i>Torrington</i>	..	Torr ridge View

In addition to the above the Welfare Committee have reserved accommodation for a limited number of residents (not sick cases) at the following premises, which are under the control of the Regional Hospital Board.

<i>Honiton</i>	..	Marlpits Hospital
<i>Newton Abbot</i>	..	Infirmery Section
<i>Plympton</i>	..	Plympton Hospital
<i>St. Thomas</i>	..	Redhills Hospital
<i>Tiverton</i>	..	Belmont Hospital
<i>Totnes</i>	..	Broomborough Hospital

Registration and Inspection of Old Peoples Homes

Any establishment, the sole or main object of which is the provision of accommodation for old people or blind or other handicapped persons must be registered with the Welfare Committee of the Council.

Handicapped Persons

Blindness

Professor Sorsby's report on the causes of blindness, as recorded in blind certificates received for the period 1951/4, was published during the year.

It is very interesting to note that whilst some 30 years ago a third of all cases of blindness amongst infants was due to ophthalmia neonatorum, this has now disappeared as a cause, due to the care taken with new born babies and, of course, to the introduction of anti-biotics in treatment. Today 80% of cases of blindness in infants is due to congenital malformations of the eye.

The other important point which emerges is that, with the increasing proportion of old people in the community, the numbers

of blind persons are also rising, since, of course, blindness is most common in the elderly. This increase is far from inevitable and Professor Sorsby draws attention to the fact that many elderly people suffering from cataract are first brought to attention through officers of the National Assistance Board, to whom they have applied for financial help. Such cases should, of course, be picked up at a much earlier age, when the patient would still be young and fit enough to undergo an operation, which would in most cases prevent the onset of blindness.

The Welfare Department is responsible for maintaining a Register of all blind persons in the County and providing Welfare services for them. The services include visiting and teaching of Braille or Moon, handicrafts, etc., by Home Teachers, arranging for the installation of wireless through the British Wireless for the Blind Fund.

A Register is also kept of the Partially Sighted, and a number of the Welfare services are also available to them.

I am indebted to Mr. D. F. Makin, Blind Welfare Officer for the information recorded in the table.

Deaf and Dumb

The Welfare Committee have appointed the Devon & Exeter Mission to the Adult Deaf and Dumb as their Agents for providing the necessary welfare services to persons handicapped by deafness. A full time Missioner/Welfare Worker is available to watch the interests of the Adult Deaf. He also helps to find employment, advises and cares for their spiritual needs.

The Missioner (Rev. W. J. B. Brown) has an office at the Welfare Centre, Exe Street, Exeter, and there is also a Centre at 44, Fore Street, St. Marychurch, Torquay.

Hard of Hearing

The Welfare Committee also make a grant to the Devon and Exeter Federation for the Hard of Hearing.

Other Handicapped Persons

The Welfare Committee have appointed the Devonian Orthopaedic Association as their Agents in the scheme for the provision of Welfare Services for Handicapped Persons other than the blind, deaf and dumb and partially sighted. The scheme at present is to provide the following:—

- (i) A Social Welfare Service to assist handicapped persons in overcoming the effect of their disabilities, to give advice on personal problems, etc., and to encourage and aid their attendance at places of worship, social centres, clubs and similar places of recreation.
- (ii) The keeping of a Register.
- (iii) The assistance of registered persons to engage in any handicraft or skilled activity without any payment being made by the Council to the person assisted.

REGISTERED BLIND AND PARTIALLY SIGHTED PERSONS

CAUSES OF DISABILITY

(i) Number of cases registered during the year in respect of which para. 7 (c) of Form B.D.8 recommends: BLIND (a) No treatment (b) Treatment or re-examination TOTALS	Cataract	Glaucoma	Cataract and Glaucoma	Retrolental Fibroplasia	Others	Total registered during year
	24 (see Note A)	5 (see Note B)	5 (See Note C)	1	*36 (See Note D)	
	36	11	6	—	24	
	—	—	—	—	—	
	60	16	11	1	60	148
PARTIALLY SIGHTED (a) no treatment (b) Treatment or re-examination TOTALS	1	—	2	—	8	
	(See Note E)	4	(see Note F)	—	17 (See Note G)	
	16	—	4	—	—	
	17	4	6	—	25	52
	—	—	—	—	—	
BLIND	15	10	5	—	22	
PARTIALLY SIGHTED	7	4	3	—	10	

NOTES:—A. In seven of these cases operations for cataract were recommended, but were refused by the blind person ; in two cases people died before treatment could be given and in eleven other cases the general physical condition prevented operation.
One case is pending.

B. Treatment is pending in one case.

C. One case died before treatment was given.

D. Treatment is pending in two cases.

E. Two have refused operations and in seven cases treatment is pending.

F. General physical condition prevents treatment in one case.

G. General physical condition prevents treatment in one case; one case died before treatment could be given and in five cases treatment is pending.

* Seventeen of these cases are persons over 70 years of age with Macular degeneration:—(i(a) Others).

SCHOOL HEALTH SERVICE

Last year I drew attention to the considerable increase in the school population over the last ten years, and the increased amount of work brought about by the introduction of new schemes. I said "A point has now been reached where additional staff will be needed if both quantity and quality of work is to be maintained." This year there has been a further slight increase in the total school population, (see table V) but the introduction of poliomyelitis vaccination, referred to earlier, resulted in a slightly smaller number of medical examinations being carried out. (See table V).

We have been especially anxious about the disproportionate amount of time the Health Visitors spend on routine school duties, and attention has been given to ways of lightening this burden. In particular a scheme was prepared for the more effective use of Nursing Assistants, and this was presented to the Committee towards the end of the year.

<i>Number of Schools</i>		<i>Number of Pupils</i>
Primary (Juniors and Infants)	385	38,545
Primary (All Ages)	18	4,062
Secondary Modern	39	14,250
Secondary Grammar	21	7,277
Secondary Technical	2	516
Special	4	278
TOTAL	469	64,928

MEDICAL INSPECTION AND TREATMENT

Examination of table V shows that there was a marked decrease in the number of examinations carried out in Primary Schools but some increase in the number of Secondary School children seen—due no doubt to the passing up of the "bulge." The drop in the number of re-inspections may be a reflection of the lower number of children requiring observation, but it is more likely that some Medical Officers were not able to re-visit all the schools in their areas for the purpose of follow-up examinations. Thus Dr. Vernon writes "this year has seen a larger number of children in the schools in my area than ever before. All the schools were visited at least once but, many schools did not have a second visit."

Age Groups for Medical Inspections

When the 1944 Education Act came into operation the Committee decided to keep the two medical inspections at 5 years and 10 years—i.e. at the beginning and end of the child's stay in primary school, and a further two examinations in secondary school—at 12 years and just prior to leaving. It was also hoped to have an intermediate examination in primary school at 8 years but this never proved possible. This has meant that the medical inspections for most children have taken place at ages 5+, 10+, 12+ and 14+, the last three examinations taking place at only 2 year intervals but there being a 5 year gap between the first two. A special record was kept during the year of new defects found in the different age groups and the findings are given in the table below.

<i>Age group</i>	<i>8 yrs.</i>	<i>10 yrs.</i>	<i>12 yrs.</i>	<i>leavers</i>
Newly discovered defects needing treatment	8%	3.5%	4.0%	4.2%
Newly discovered defects needing observation	35%	17%	15%	12%

The figures for the 8 year olds must be interpreted with caution since they are based on small numbers, and since a number of these children may have entered maintained schools late this examination is their first. It is felt that, if we can maintain our policy of four exams during the school life of every child, it would be more logical to space them at ages 5+, 8+, 11+ and 14+. The Committee will have to face the possibility that without an increase in establishment it may be necessary to reduce the number by dropping the present 12+ exam and leaving three at 5+, 10+ and 14+.

Nutrition and General Care

Last year I questioned the value of trying to assess the nutritional status of children as A, B, or C. As from this year the Ministry of Education only require classification as "satisfactory" or "unsatisfactory" although one still wonders whether the figures will give any valid comparison between different areas.

The general health and physique of the school children and standards of parental care appear high in general, although there are inevitably some exceptions. Dr. Hinde reports:—

"The commonest defects are still with the feet and posture, but these respond well to corrective exercises if the child can be persuaded to do them regularly."

Dr. Green is concerned about some children in her area who are inadequately clothed and without "woollen or other warm underwear in the coldest weather, and many of them patently feeling the cold."

Enquiry in such cases often reveals that the income is spent on Television, or a car, and frequently both, before the needs of the children are met. "Presumably Luxury before Necessity is the order of the day in the Welfare State, as it relates to these families," she states.

At the other extreme come mothers who seem over protective as recounted by Dr. Archer:—

"Fortunately, there are few children who come to school either dirty or insufficiently clad, but how numerous are the mothers who over-clothe their younger children! "He has more skins than an onion" remarked one mother with some satisfaction in her voice as she peeled off garment after garment in preparation for the examination. I counted six layers of wool on the child without the outer coat on a mild Autumn day. Clearly some mothers need a revised notion of the clothing requirements of their younger children. I have never seen an over-clad school leaver, so apparently teenagers resist successfully any attempt at over-clothing them."

Dr. Budding has also found examples of imprudent hire purchase and says:—

"I have noted however that in one or two cases where children have been brought to my notice for bad attendance through frequent sickness, that they have ceased to take school dinners, are poorly shod and have become poorly dressed, all only recently. On investigating a little deeper I have been rather upset to find that the family has recently bought a T.V. set and is finding the payments difficult. In fact one family tried to 'have it both ways,' as the 10 year old boy asked the teacher for a form for free dinners 'as we cannot afford to pay now that we are paying weekly for a T.V.'. Relative values!"

Many mothers now apparently go out to work in order that the family can afford to make such purchases without being deprived of basic essentials. This brings with it other problems. Dr. Epstein finds that more and more mothers are going out to work. She has examined children sent to school obviously unfit to receive education—they have even had temperatures and been suffering from such conditions as acute gastro-enteritis, tonsillitis, dental abscesses, and have been a potential source of infection at school.

She says: "Often the Nursing Assistant takes the children home, with a letter explaining why they are not fit for school and requesting that their family doctor should be consulted, only to find the house locked up and she has to bring them back to school. At school the child is usually isolated and often a teacher has to sit

with an ill child all day. The teacher cannot be expected to diagnose one condition from another and she must not be expected to shoulder all the mothers' responsibility.

Mothers must realise that they are sending ill children out to school; from case histories it is obvious that most of these children complained of symptoms before leaving home. What is happening to the moral responsibility of these mothers?

Does the mother *have* to work as well as the father or is she just paying for luxuries such as television? Does she consider such luxuries more important than her child's sense of security. This is a real problem which seems to be getting worse."

Dr. Kingdon writes in the same vein following an outbreak of measles at a school in his area:—

"What I did notice most markedly was the poor condition in which many measles convalescents returned to school. They were listless and pale and in the dining room I noticed, particularly, their poor appetite. They were in no fit state to resist further infection. On enquiry I found in many cases that the children were sent back to school on the very first day after quarantine irrespective of their condition in order that the mother might go back to work. From this one can draw one's own conclusions."

School Clinics

During 1956 the Ministry of Education approved plans for the much needed new clinic building at Tavistock, but building had not commenced by the end of the year. The project for a new clinic at Brixham was again deferred, but it has been agreed to include it in the capital estimates for 1958/59. A site, adjacent to the Grammar School, has been earmarked for a new Exmouth clinic, but it is unlikely to be built for several years as new accommodation is even more urgently needed in other parts of the County. The services remaining at Boutport Street clinic, Barnstaple, were transferred to the Alexandra Road clinic, and the tenancy of the former premises relinquished in March.

The cumulative effect of postponement of our various capital projects means that many old premises will have to serve for a considerable number of years yet, and the Committee will be faced with an increasing expenditure to modernise and maintain these.

The figures for minor ailments treated at school clinics (see Appendix, Table IX) have been kept in a simplified form this year, and are thus not easily compared with those for previous years. It is probably correct to say that the most valuable function of these clinics today is to enable the Medical Officer to see children referred from school medical inspections in more advantageous conditions of accommodation and time.

Consultation Scheme

The number of children referred to various Consultants, with the approval of the family doctor, has again fallen somewhat. The majority are still sent to E.N.T. Surgeons for opinion as to the need for tonsillectomy.

E.N.T. Surgeon	..	..	..	389
Orthopaedic Surgeon	..	..	..	148
Dermatologist	..	..	..	41
Chest Physician	..	..	..	28
General Surgeon	..	..	..	26
Paediatrician	..	..	..	26
Cardiologist	..	..	..	12
General Physician	..	..	..	5
Plastic Surgeon	..	..	..	3
Thoracic Surgeon	..	..	..	2
Neurologist	..	..	..	1
				<hr/>
				681

THE SCHOOL DENTAL SERVICE

Mr. J. Fletcher, L.D.S., R.C.S., Eng., Principal School Dental Officer, reports:—

Staff

In October we welcomed to the staff the return of Mr. P. F. G. Whitfield who was re-appointed Dental Officer at Barton Clinic, Torquay. Having completed a post-graduate appointment on orthodontics at the Eastman Dental Hospital, London, and having gained a post-graduate diploma in this speciality he now shares with Mr. Peacock the specialist orthodontic service in the County, devoting at the outset approximately 1½ sessions weekly to specialist orthodontics.

At the end of the year the dental staff, including myself, numbered 18½ expressed in terms of whole-time dental officers, a near approach to the authorised establishment of 19, and giving a dental officer—school child ratio of 1 : 3,514. Unfortunately on 31st December two resignations became effective, namely those of Mr. G. Baker and Miss B. Simpson, causing vacancies in the Holsworthy—Okehampton and Exmouth areas, with no apparent immediate prospect of their being filled.

In October, 1956, the Inter-Departmental Committee on Recruitment to the Dental Profession—better known as the McNair Committee issued its report. From this it became clear that an

alarming drop in the strength of the dental profession is to be expected during the next ten years. The Report stresses the need for dental health education not only to inculcate in the minds of the public a proper appreciation of the value of dental health but also to bring the possibilities of dentistry as a career to the notice of boys and girls at a suitable stage in their Grammar School careers. Visits to a number of schools to talk to the boys and girls have been paid by myself and some of my colleagues and to show dental health films. These visits have in general been very well received. Although a few years ago suitable condidates for entry to the dental profession were not coming forward in sufficient numbers to fill the vacancies in the dental schools, the reverse is now the case, but a still greater dilemma exists in that even with the places in the dental schools completely filled there will still be insufficient entrants to the profession to maintain the strength of the register let alone to increase it so as to meet more nearly the dental requirements of the nation.

Treatment

The wide range of treatment referred to in earlier reports still continues to be given by the County Dental Staff. In my report for 1955 was figured a graph showing the rapidly increasing number of fillings necessary in children's permanent teeth which had followed the first tentative de-rationing of sweets and sugar. In 1955 the average number of fillings in permanent teeth had increased from .95 in 1950 to 1.44. This figure has shown a further sharp rise to 1.65 in 1956. The increasing incidence of dental decay in children's teeth commented on by many dental officers and referred to in "The Health of the School Child" for the years 1952 and 1953 and again in 1954 and 1955 shows as yet no sign of being halted.

Below are given details of treatment per 100 children treated, compared with figures for earlier years.

Treatment per 100 Children

<i>Type of Treatment</i>	1950	1951	1952	1953	1954	1955	1956
FILLINGS:							
In Permanent Teeth (No. of teeth filled) ..	95 (83)	109 (94)	130 (114)	135 (118)	136 (117)	144 (124)	165 (144)
In Temporary Teeth (No. of teeth filled) ..	11 (—)	14 (12)	17 (14)	16 (17)	20 (20)	22 (20)	22 (21)
EXTRACTIONS:							
Permanent Teeth ..	13.2	14.8	16.1	16.5	18	25	27
Temporary Teeth ..	89.4	75.5	80.2	67	79	72	83
Other Operations ..	72	97.5	100.3	99	92	103	118

Dental Health Education

As foreshadowed in my report for the year 1956, Dental Board Dental Health Education Films were obtained for periods of 1 and 2 weeks in both the spring and summer terms respectively and were successfully shown on the health department sound film projector at 33 schools and 7 Parent-Teacher Associations until petrol rationing put an end to such activities at the end of the year. There is no doubt at all as to the value of such talks and film showings.

Fluoridation of water supplies

Fluoridation of water supplies is now being carried out in four study areas in England, Scotland and Wales, three of which began in 1956. Recently the Minister stated in Parliament that fluoridation was "undoubtedly the most promising of all the measures affecting preventive dentistry" and added that once it was established to the satisfaction of all concerned that the materials, the machinery and the technique were available and understood the experiment would be extended on a much wider scale. It would therefore seem that the Minister of Health may soon be contemplating the sanctioning of fluoridation schemes as purely public health measures for the control of dental caries in young people.

Clinics

No new static clinics were opened during 1956 but plans for the new combined medical and dental clinic at Tavistock were well advanced. One new mobile dental clinic was purchased in March, 1956, and with the other four has been in constant use ever since. Schools not before visited by Mobile Clinics until 1956 included Yealmpton Primary, Fallapit House, East Allington, Combe Martin County Secondary and Primary, Newton Poppleford Primary, Landkey, All Saints Primary School, Sidmouth.

Orthodontic Treatment

The County orthodontic scheme is based on the three assumptions that (a) a certain number of cases can be treated unaided by the dental officers themselves; (b) that a further number of more complicated cases can be treated by the dental officers under the guidance and supervision of an officer or officers with special knowledge of the subject and (c) that the most difficult cases are treated entirely by the specialist officer or officers. This system has the advantage of adding interest to the day to day routine work of the dental officers, enables them to increase their interest and knowledge of the subject and brings the expert knowledge of the specialist to bear on as large a number of cases as possible in the time which in the judgement of myself and the Principal School Medical Officer

can properly be devoted to this subject without unduly encroaching on the more essential work of ordinary dental care and maintenance. A number of dental officers might wish to devote more time to orthodontics but they realise that time devoted to this work, important though it be, must be kept in proper relationship to routine dentistry in order to avoid there being too long a period between routine dental visits with, in consequence, an ever increasing amount of treatment being necessary per child.

Until October 1956 Mr. A. S. Peacock, Plymstock Clinic, was the only dental officer on the staff possessing a post-graduate qualification in orthodontics, but in October he was jointed by Mr. Whitfield, Barton Clinic, to whom he handed over a number of his clinics on the eastern half of the County. This enabled him to pay more frequent visits to North Devon, which increased facilities have been favourably commented on by the dental officers in the Bideford and Barnstaple Urban and Rural Districts. Figures for orthodontic treatment during 1956 are as under:

Number of new cases commenced	..	..	333
Number of cases carried forward from 1955	..		375
Number of cases completed during the year	..		229
Number of cases discontinued for other reasons	..		79
Number of cases treated with appliances	..	..	309
Number of fixed appliances fitted	..	..	7
Number of removable appliances fitted	..	..	422
Number of attendances made for orthodontic treatment			3,687

It is a pleasure again to record the extremely cordial relationship which almost invariably exists between the dental staff and the teaching staff of the schools. Their cordial and active co-operation adds so greatly to the success of the work."

Several Medical Officers also refer to the high incidence of dental caries. Typical comments are those of Dr. D. MacTaggart:—

"The present generation of school children have had the benefit of welfare foods and vitamin supplements in babyhood, dinners and free milk at school, and for the last 9 years, the great advantage of free medical and dental treatment, and one feels that these things should have led to a marked improvement in dental health. Yet I am continually appalled, though no longer surprised, at the amount of dental caries which I see at routine medical examinations. I feel that more frequent routine dental inspections and concurrent health education directed at better oral hygiene would help a great deal."

HEARING TESTS

Dr. Archer has submitted the following report:—

“ From the beginning of the year I added simple voice tests for the hearing of speech to the ordinary routine of periodic medical examination in all age groups. It seemed likely that testing five-year olds by this method might prove difficult but it has, in fact, been unexpectedly successful. A small number of children are reluctant to attempt the test in the presence of their mothers, but perform it with precise efficiency and sangfroid later when alone. The accumulated experience of the year emphasizes the fact that any five-year-old who does not complete the test in a normal manner needs careful consideration and observation, if not for hearing loss, for other equally important reasons.

A brief summary of the numerical results of testing is given in the tables appended. It will be seen that over the whole year 1.6% of the children tested were referred to an Otologist for investigation of suspected serious loss of hearing.

TABLE 1

Tested	Noted for re-testing and observation including speech defects.	Referred to Otologist.
1890	320 i.e. 17%	30 i.e. 1.6%

TABLE 2

Reports and Treatment of Children Referred

Upper respiratory tract infection	10	Recommended removal of tonsils & adenoids	9
Upper respiratory tract infection with otitis media	3	Already tonsilectomised	3
Otosclerosis	5	Hearing-aid given	4
Nerve deafness (Erythroblastosis)	1	Hearing-aid given	1
Speech defects with normal audio-gram	3	Speech Therapy	3
Awaiting final reports of investigation	8		

I think it is a justifiable claim that these voice tests provide a very simple and relatively rapid method of screening school children for hearing loss, in order to pick out those who need more detailed investigation. An additional advantage is that speech can be assessed at the same time as hearing by these tests. This is very

valuable in every age group, but particularly in the entrants group, where speech defects are common and where most children tend to be silent at the examination unless there is some special inducement to speak.

Many points of interest emerged from these tests, suggesting profitable lines of further observation; one or two may be just mentioned. Some of the children with serious and unsuspected hearing loss had considerable skill in lip-reading and were unwittingly using this to mask their defective hearing. In two or three of the older types of school-building, where the class-room acoustics were found to be poor, a small number of tests, specially directed to this point, suggested that some of the children with normal hearing had also learnt to supplement their hearing by the visual aid of lip-reading. It would be fascinating to have the time and opportunity to explore this indication more thoroughly.

Simple sentences were part of the test and the freedom with which some children omitted and interchanged the definite and the indefinite article indicated that auditory attention and accuracy is often poor when hearing is normal. I have occasionally pondered on the notion that accurate listening is a dying art and that possibly, the present emphasis on visual aids in all forms of teaching may be partly responsible for careless listening.

The paramount value of auditory training is now clearly recognised as a vital part of the treatment of deafness, particularly in children. It is a most unfortunate defect in the Health Services at present available in this County that no provision is made for such training. The astonishing and comparatively rapid improvement in the unaided hearing of some deaf children when given hearing aids suggests that the hearing-aid is used as a means of rehabilitating defective hearing by successful listening, in other words by auditory training. This seems to be to provide a very sound argument for the treatment of minor degrees of hearing loss, under the supervision of an Otologist, with auditory training as soon as they are discovered. At present, if there is no indication for surgical treatment, we tend to make no attempt at treatment until the deafness reaches hearing-aid severity. Where better could this early, preventative treatment be started than in the School Health Service?"

Hearing Aids

Dr. Archer, referring to the figures in the table, continues:—"Of the five children provided with hearing aids, I think one can say that they all showed marked subjective improvement quite rapidly. They said their aids helped them, although they also said it was sometimes difficult to tolerate the amplification of extraneous noises in school, in order to hear voices better. I have wished on several occasions that I had been able to photograph one or two of

these children before the provision of a hearing aid, and after. The change of facial expression is very revealing; before treatment there is the remote, apathetic, expressionless look of the deaf child, with the occasional swift, questioning glance when something has penetrated the deafness and “rung a bell”—or, with older children, the polite, attentive, careful attitude with head cocked to the optimum angle and eyes anxiously fixed on the speaker’s face. In one or two of these children the change to a lively, alert, relaxed expression of the normal listening child became most apparent in a few weeks.”

Dr. Budding also refers to children who have received hearing aids and says:—

“A large number of these children are no longer “handicapped” as with hearing aids they are at no considerable disadvantage. Follow up clinics are invaluable, and do ensure that the child is using his aid to maximum effect and not just wearing it.”

Developmental Aphasia and Speech Defects

Dr. Archer also reports:—

“In using speech tests on hundreds of children one becomes aware that some of them, with apparently normal pure tone hearing, have a poorer comprehension of speech than is normal for their age. They are backward in speech development. This is encountered most commonly, of course, in the five-year-old examination: frequently in the form of speech defects, less commonly in more severe forms. Six children were met during the year who had entered school still, to all intents and purposes, without speech. Three of these children, all girls, quite evidently had extremely limited understanding of speech. In other words they were suffering from a developmental aphasia which was both receptive and expressive. These children present a special problem in the ordinary school. The tendency is to regard them as mentally defective or, at least, as of low intelligence on account of their lack of speech and the behaviour problems that arise from their inability to understand speech. It is clear, however, from observation and from the published reports of detailed investigations in particular instances, that this specific disability may occur in association with all grades of intelligence. Even in less extreme cases careful observation and supervision is required. The child comes to school with a very small vocabulary, numerous speech defects and poor capability in sentence building. These defects obviously constitute a considerable handicap to normal educational progress, but the more severe handicap of lack of understanding for speech is often misconstrued as wilfulness and stupidity. The companionship of normal, speaking children, is I feel, almost the most important part of the education treatment of these children.”

TUBERCULIN “ JELLY ” TESTING

At the commencement of the school year in September, 7 year old children were taken in to the “ jelly ” testing scheme. During the year 1955/56 7,737 children were tested, 4,468 of these being 5 year old children tested for the first time and 3,269 being 6 year olds who had been tested the previous year. Only 4.2 % of the school entrants were tuberculin positive, as against 6.8 % in 1954/55. 34 children (approximately 1 %) of those re-tested had converted.

The scheme is part of a wider scheme for prevention of tuberculosis, and has already been described in greater detail (pages 12 to 21).

HYGIENE EXAMINATIONS

1956 again saw a reduction in the number of pupils found to be infested, the rate being only 0.25 % as against the previous record low level of 0.37 % in 1955, (the latter figure being incorrectly recorded in my 1955 report as 0.65 %).

Whilst it remains true that this satisfactory fall is to some extent the result of constant vigilance, examination of the figures showed that certain schools have been completely free of infestation for upwards of 5 years. A decision was thus taken to arrange only an annual hygiene examination in such schools, but to revert to a termly inspection for at least two years should any case occur in one of these schools. It is hoped that this experiment will save much unproductive work for the Health Visitors without any deterioration in standards of hygiene

VISION TESTS AND SCHOOL OPHTHALMIC SERVICE

The vision tests carried out on every pupil each year are invaluable in picking out defects as early as possible and referring the children to one of the School Ophthalmic Surgeons. We have, however, set ourselves a high standard even though our staffing ratio of Health Visitors is below the average. On account of this the carrying out of these tests at less frequent intervals was considered during the year. I was loth however to suggest such a retrograde step to the Committee.

The School Ophthalmic Service has continued to run quietly and efficiently during the year. Dr. Foxwell has submitted the following report on the important question of lighting in schools and its effect on vision.

“A recent query on fluorescent lighting suggests that possibly a short general survey on lighting and vision might be of interest, though to condense such a vast subject into a short readable report is not easy.

Adequate DAY-light is a primary requisite, though it is probably not realised for how many hours artificial light is required in schools. One report from an urban area estimates no less than 70 full working days in a year, though this would be appreciably less in rural areas where smoke, crowded buildings etc. are not so dense.

The Ministry of Education requires a minimum daylight factor in new schools of 10 units of light (known as lumens), but in old premises considerably less is often available, so at once it becomes necessary to divide consideration between post and pre-war buildings. The former can be dismissed almost at once from discussion because in these the lighting has been in the hands of experts and is almost completely adequate, the only grave omission from my point of view being the lack of space, and darkness—not light—for ophthalmic examinations!

The old buildings, of course, range from the 'ancient monument' to immediately pre-war types. In the former the lower window sills were often placed well above the pupil's head, thus preventing non-academic distractions, but at the same time effectively reducing the light, and often adding simultaneously leaded lights and even stained glass for good measure.

The siting of desks is also most important. In one such school that I visited recently, the light on the teacher's desk on a brilliant sunny day was approximately 10 lumens per square foot, the pupil's desk immediately in front varied from 15—20 lumens per square foot, but on the desks to the side and immediately under the high side windows, though not more than 4ft. away, the reading was only 6 lumens per square foot. Electric light was available, and had indeed been supplied but the sources were placed centrally and the side desks while receiving an adequate supply, were at a disadvantage. It is in these and similar cases that fluorescent lighting, placed parallel to windows is to be recommended owing to its near-daylight colour, with which it blends. If desired, switching on can be automatically controlled by photo-cell, and thereby made dependent on the amount of natural light available.

What made the readings at this school even more interesting was that a new classroom had been recently erected and was in use. In this, the teacher's and pupils' desks reached 40 lumens per square foot accompanied by complaints of too much light, or glare, at certain times of the day! So that the demand is not merely for more and more light, but for effective and controlled, i.e. glare-free light, in every case sufficient for the job.

The problem is gradually solving itself as the building and reparation programme proceeds. Much, of course, can be done in small ways without excessive expense, even the removal of trees, outbuildings, etc., will often make considerable difference.

Interior decoration and fittings can greatly increase, or otherwise, the available light on working surfaces, simultaneously enhancing conditions generally from a visual point of view. Most of the new decorations achieve the correct reflection factors and are most pleasing.

Ceilings should be, and usually are, white or off-white, giving 70% reflection factor. This is unfortunately impossible to obtain with the old lofty church-type rafted ceiling, which duly absorbs much of the light—and heat—of the room below, and must be most depressing under which to work. Nevertheless, even this difficulty has been overcome in some schools by the provision of a lower plain ceiling.

Desks and working surfaces should not make too marked a contrast to white paper usually placed on them, but on the other hand must be reasonably dark, owing to constant and often grubby usage. The reflection factor should be about 25%. The whole classroom should give an impression of pleasing brightness on entering, even on a dull day, for this not only, it is hoped, increases mental alertness, but conveys an air of cheerfulness and spaciousness.

The recent expansion of electrification of villages in Devon is a great boon, and simplifies the question of supplementary lighting. Finance, as always, is a moderating factor, but the somewhat heavy installation costs must be weighed against the years of trouble-free use the apparatus will give in uniform and effective lighting.

Light and Vision

It is perfectly true that poor lighting will not cause errors of refraction, such as hypermetropia (long-sight) or astigmatism, though it will lead to symptoms commonly designated eye-strain, and *car*, in company with other factors, accelerate and increase myopia in children. It has been stated that a higher degree of illumination is required for subjects with defective vision, but this is only true of pathological defects which cannot be corrected optically, hence the added necessity for early specialist examination and correction of refractive errors.

Symptoms of eye-strain are definite, though they vary considerably between subjects and age-groups, and are onset by many conditions, bad lighting, bad posture, severe glare, etc., and excessive televiewing! The large number of queries received from parents and others denote the interest taken in the last named. The answer for preventing strain is the usual one of common-sense, restricting viewing times to reasonable hours and periods consistent with age-groups of subject, low light in room placed to side or rear of viewer, and adequate distance from screen, not less than 6ft. These have already been stated and are generally understood and followed, especially when the original novelty of a new T.V. set has worn off.

Another query frequently raised by parents is the advisability of sun-glasses for children, so that a word of advice may not be out of place here, though the subject may not be topical when the report is read! Apart from pathological conditions, where they are part of treatment, it is of course beneficial for children to wear sun-glasses on bright sunny days, especially at the sea-side or near water, where the glare is from above and again reflected from below, though it cannot be too strongly emphasised that where children have an error of refraction, especially with any degree of myopia, their own properly corrected glasses will render even bright light more glare-free than uncorrected plain sun-glasses. In these cases it is better to wear *light* clip-on or attachable dark lenses, preferably in mica or other light-weight unbreakable material.

Nutrition and Muscle Balance

Further evidence, if any were required, of the excellent nutritional standard of Devon County school children is available in the now comparative rarity of cases of convergence deficiency. These may arise from a variety of causes, but large numbers were especially striking in 1945/46, when nutrition was so low.

In several cases children affected had, for other reasons, been removed from unsuitable homes where neglect and malnutrition were rife, but after 2—3 weeks in surroundings of regularity, cleanliness and good food, the condition vanished without any other treatment, even exercises. That the affection is now so comparatively rare I consider due to improved living conditions generally."

SPEECH THERAPY

The Education Committee's request for a fourth Speech Therapist came before the Establishment Committee early in the year, and the increase in establishment was approved. We were not able to fill the post until the autumn when Miss Aylen took up duties in the South-Western part of the County. The new area centred at Plympton consists of clinics at Plympton and Plymstock taken over from Miss McMillan, Tavistock and Maristow House School from Miss Chapman and Okehampton from Miss Phillips. At Tavistock, Maristow and Okehampton, one extra session per week is held at each clinic since the change over, and it is hoped that shortly a clinic will be opened at Kingsbridge.

Miss McMillan has been able to devote more time to the Torbay Area, and open a clinic at Dartmouth. In this area there is still a waiting list totalling 85, but this has been considerably reduced on 1955 figures. Group treatment has undoubtedly helped to reduce this figure. It has been noted that attendance has greatly improved in this area in the past year, though this will not show in the total

figures due to the absence of the Speech Therapist for four months owing to sickness.

In the North Devon Area there have been no new clinics opened, but a considerable reduction in the waiting list has been achieved. Travelling to clinics in this area presents considerable difficulty owing to very poor transport from scattered villages.

In the East Devon area the Honiton clinic was re-opened for regular weekly sessions, and a new clinic was opened at Seaton where there was a waiting list of 17. In this area also there is difficulty with infrequent public transport.

CHILD GUIDANCE

The "Underwood" Report on provision for maladjusted children which was published towards the end of 1955, was carefully considered by a Special Sub-Committee early in 1956. The report suggested that there should be a comprehensive child guidance service available in every area, and that it should be a part of the School Health Service and be closely linked with the School Psychological Service. The general pattern should be for the Education Authority to provide premises, psychologists, psychiatric social workers and other ancillary staff, and for the Regional Hospital Board to provide the Psychiatrists. On the recommended staffing ratio Devon would need the equivalent of at least $1\frac{1}{2}$ Psychiatrists, 3 Educational Psychologists and $4\frac{1}{2}$ Psychiatric Social Workers.

Following the resignation of the Medical Advisor in Mental Health, it was decided to appoint a County Psychiatrist who would devote about half his time to clinical work in the Child Guidance Clinics, and the Regional Hospital Board agreed to pay a proportion of his salary in respect of Child Guidance work. We welcomed Dr. W. Hinds to this new post in July. Agreement was also reached with the Hospital Board that they would take over the services of Dr. Gaussen, on a part-time basis, and second him to work with the County Child Guidance Service for 2 sessions per week, although the Council was to continue to pay 75% of the cost. Efforts are being made to persuade the Regional Hospital Board to accept full financial liability as recommended by the Underwood Committee.

Dr. Gaussen is responsible for the service in East Devon, working from the Exeter clinic, whilst Dr. Hinds has taken over the Torquay and Barnstaple clinics. In the South-West of the County we have continued to avail ourselves of help from the Plymouth City Service. We thus now have the equivalent of about three quarters of a full-time Psychiatrist. Early next year Miss Yeo will return as a qualified Psychotherapist, and will be able to relieve the Psychiatrists of some treatment sessions.

Miss Yeo will not be undertaking as much routine intelligence testing as her locum, however, and the position concerning Educat-

ional Psychologists will worsen unless the recommendation for the appointment of a fourth psychologist is accepted. Dr. Star of course has certain administrative duties, whilst Mr. Maliphant devotes half his time to the Children's Committee, so that there will in effect be nearer the equivalent of two rather than three Educational Psychologists next year.

A recommendation was also made for the appointment of a third Psychiatric Social Worker immediately and a fourth from the beginning of the next financial year. The establishment was increased to three, the question of the fourth P.S.W. being deferred until after the third post had been filled.

This year an important step was taken in the linking of the Child Guidance and School Psychological Services. The administration of the Child Guidance Service was transferred from the Mental Health Section to the School Health Section, and concurrently the Chief Education Officer agreed that pending the erection of the new County Offices the Education Psychologists should work from the Medical Department, where accommodation has been provided alongside the Psychiatrists and Psychiatric Social Workers. This has proved of inestimable benefit, and has for the first time provided a unified and co-ordinated service.

Clinic accommodation is still a problem. In Exeter we continue to rent a City Council clinic on two days per week: whilst the buildings are satisfactory for ordinary clinic use they are somewhat inadequate for Child Guidance purposes. At Torquay we have our own premises in the basement of the Castle Road Clinic, but to say the least they are cramped for space. When the Barnstaple Boutport Street Clinic was given up, the Child Guidance moved with other services to Alexandra Road: there the accommodation is definitely cleaner and more cheerful but not so spacious, and difficulties may arise with an expansion of the service.

Dr. Hinds reports as follows:—

“Prolonged unhappiness in children is usually a measure of emotional unsatisfaction. Much emphasis has been publicly focused on this common condition which leads to maladjustment.

The upheavals of two major Wars within a quarter of a century of each other have been quite potent factors in precipitating the present age of increased stress of living, from which springs much maladjustment.

Human beings can be thought of as a body—mind unity, in which the mind influences the body to produce bodily symptoms and in which the body influences the mind to produce symptoms in one of the three classical divisions of the mind, namely in thinking, feeling and willing, or behaving. So we can get (1) a poor learning

achievement, where far better ability exists; (2) an obvious instability of emotion or feeling; (3) behaviour, although limited to a person, may be an obvious sign of stress to others, e.g. tics, grimaces and habits; (4) unstable behaviour that affects others, e.g. unsociability or violence; (5) various pains and aches in different situations, suggesting bodily illnesses, but springing from fears; and so on, all springing from emotional unsatisfaction.

Compensation may not always be adequate to stress, e.g. a child may from birth be crippled, so that it cannot compete with other children in running about, yet later that child may show problems due entirely to an undue urge for muscular activity. A deaf child, again, may recede into a world of its own, giving a false impression to people around it; on the one hand, it may seem mentally defective and apathetic for most of its time and yet, in moments of extreme frustration, it may react with a great deal of violence. Often, a nervous child of high intelligence does show much backwardness in arithmetic, whereas a stable child much less gifted would be much more competent. The variety of problems offered to Child Guidance Teams is really limitless.

Samuel Butler in 'Hudibras' has the following couplet:—

‘ He that complies against his will
Is of his own opinion still ’

The essence of Child Guidance activity is to help children and parents to *convince themselves* of the need for a change in their behaviour, feelings, thoughts or relationships—probably to each other. A Child Guidance Team can assist by leading them to the point of decision, but, to achieve this, it requires in the persons concerned (Children and adults) that they have a certain dexterity of mind, to be able to introspect, relax and allow long forgotten memories to revive and to recognise these as their own true past experience. The Child Guidance Movement started in this country in 1929, with the stated object of assisting children of normal or supra-normal intelligence, and, for the reasons given, it is easy to see why psycho-therapy is impracticable for anyone below a low average intelligence. Unless a child or parent can grasp the need for a lasting change in their own outlook, it is not feasible to continue the Child Guidance methods.

There are a great number of children and adults of the dull range of intellect, that is well above the mentally defective level, but below average, who do need help and provide a very great problem as to how they are going to get it. For these, there are no well recognised legal or social provisions for help, as yet. It might easily be that wider liaisons between the Child Guidance Service and the School Health Service in general might provide an answer for the

future, as, for example, by way of the wider ministrations of Health Visitors.

When a Child Guidance Team has investigated a case, then the Case Conference is a very valuable proceeding. Pooling findings and knowledge is now second nature with Clinic personnel. Many points of view bearing on the problems of a single child may not offer a solution for after treatment and management, but the chances are that they do give a greater understanding, if the Conferences are conducted carefully and systematically; and it is to be hoped that, increasingly, Head Teachers, Children's Visitors, Probation Officers, local Ministers of Religion, even doctors, if they have the time to spare, will be invited to take part in these Case Conferences; not all at one time, but according to the particular child or children concerned.

Dr. Budding is appreciative of the arrangements made to see children elsewhere than at the three main clinics. She writes:—

“Following on from this it has been an excellent innovation this year to start temporary Child Guidance clinics, where they are needed. This has been of particular value in my rural area where before it was impossible to suggest an appointment miles away. It was waste of time as the parents could not be expected to attend with the children for any regular time, and of course they refused to allow the child to go to a hostel for observation. In the rural parts of Devon even now the majority never go more than 10 miles from home even on pleasure, therefore we cannot expect them to willingly let their children leave home for any other reason.”

The Underwood report stressed the importance of prevention rather than cure, and we intend to use the skilled help now available towards this end as soon as the long waiting lists of cases for urgent treatment have been broken down.

Dr. Proctor Sims refers to this need to provide treatment more promptly than has hitherto been possible, and for more preventative work in the earlier stages by School Medical Officers and health visitors and she says:—

“One point I should like to make is the need of earlier diagnosis and treatment in the many cases of maladjustment that occur in school children. Many children are not seen or dealt with until they are in the senior schools and then, when referred, there is the inevitable wait for the over-worked Child Guidance clinic. I feel that School Medical Officers should be able to cope with more of these cases in their early stages and thus help the children more in their school lives, do more in the prevention of mental ill-health and also relieve the pressure on the Child Guidance clinics. This would mean more time to visit schools and parents and be more truly the school doctor.”

HANDICAPPED PUPILS

In accordance with the decision reached last year at the Regional Conference of Education Authorities in the South-West, the Chief Education Officer and I have attended further meetings of Officers to discuss future provision for handicapped pupils. There appear to be no undue difficulties in placing Blind and Partially-sighted children and the waiting lists for the Deaf and Partially-deaf are expected to disappear now that the " bulge, " due to maternal-rubella in 1940/41, is passing out of school. Whilst in many ways it would be desirable to have a school for epileptics in the region it is understood that, nationally, provision is more than adequate so it is most unlikely that the Ministry of Education would sanction the building of a new Special School in the South-West.

Physically Handicapped

Several authorities shared with Devon the problem that many physically handicapped children who require residential care were placed in schools situated far from their homes—some as distant as Kent and Cheshire. Waiting lists were long and, not surprisingly, some parents were reluctant to let their children go so far away. Included in the development plan for Devon is a school for physically handicapped and delicate children to take 100 pupils from the region as a whole, and it was tempting to press for the early provision of this school. Some authorities felt that it would be almost as difficult to persuade parents to let their children come to a school 70—80 miles away as to one 200—300 miles from home, and doubted whether they would make much use of such a school.

A detailed and comprehensive review was undertaken of all physically handicapped and delicate children in the County. Many were adequately catered for in ordinary schools, and, since they were able to live at home, such arrangements are ideal and teachers and others are to be commended for their help. Typical comments of the School Medical Officers are:—

“ Physically handicapped children I find very well catered for in the schools and all, especially the small Primary Schools, are particularly helpful with difficult cases. All seem willing to make special arrangements.” (Dr. Hinde.)

“ All the children in my area are being quite adequately catered for in the ordinary school and where necessary transport arrangements have been made in order to get them to school and special attention is given to the children to see that they get the greatest benefit from their education in the ordinary schools by their teachers, who have been found to take special interest in these unfortunate ones.” (Dr. Anderson.)

“Physically handicapped children are received in schools very sympathetically—in fact they are almost welcomed—by both teachers and children and all vie with each other as to who can help best—at the same time, they seem instinctively to know how to avoid molly-coddling the child.” ~ (Dr. Vernon)

Finally:—

“The schools in this district are particularly helpful in dealing with handicapped children. There are several children in this area who are handicapped to an appreciable degree who are being dealt with most satisfactorily in ordinary schools. I think that the ability to keep handicapped children in ordinary schools depends almost entirely on the quality of the teachers and their desire to co-operate. We are very fortunate in this district.” (Dr. Walker)

There are a number of physically handicapped children, however, who can (and therefore should) attend ordinary schools but would benefit from more regular physiotherapy than could be provided by infrequent visits to distant hospitals. Thus Dr. Davidson writes:—

“In this area where schools are widely scattered there are a number of severely handicapped children who are attending ordinary schools sharing a normal education and life with their fellow pupils. This would not be possible were it not for the understanding and willing voluntary co-operation and help given by teachers and the other children. This is a growing example of a very fine spirit of service which both the teachers and school children do and can give to help their less fortunate colleagues. It deserves the highest praise and encouragement.

There are quite a number of these children suffering from physical defects which are so severe as to require the provision of special facilities. I feel strongly that much more could be done to help these children to overcome their infirmities. I have at present a number of children suffering from loss of function in one form or another for whom physiotherapy and occupational therapy would greatly enhance their prospects of becoming useful citizens able to fend for themselves adequately in after life.

The main difficulty is getting children regularly to a centre for treatment as their homes are scattered over a wide area, but this could be overcome by bringing all these children into centres where there is a Secondary Modern School and Transport is already laid on. Secondary school children are brought in any how, and there should not be insuperable difficulty in bringing in the few a little younger to Primary Schools.

Physiotherapy could be provided in existing accommodation at such centres.”

Some children are so severely handicapped as to make it impossible to provide for them adequately in ordinary schools. Dr. Vernon reports:—

“ One child in my area is confined to a wheeled chair and fortunately the school he attends has no steps, but the difficulty is transport. He and his chair have to be lifted in and out of the van that takes him to and from school, but apparently the difficulties are very real for his attendance is very erratic.”

Such children are well catered for in the Torbay area since they can attend the Steps Cross School in Torquay, but those in other parts of the county are at a disadvantage. At the time of the Survey there were 16 children away at school elsewhere, 8 of them far from the South-West region. A further 16 were attending ordinary schools but were felt to need special educational treatment, but included in these were some children referred to by Dr. Davidson as able to attend ordinary school if physiotherapy were available. There were another 17 pupils so seriously disabled that they could not possibly attend ordinary schools and were receiving a limited amount of home tuition.

From discussions with Medical Officers of neighbouring authorities and from informal talks with Officers of the Ministry I have some doubts as to whether we are likely to obtain approval for the building of a new school, even though there is need in the region, since it is anticipated that within a few years enough places will be available nationally.

Now that the kitchen at Steps Cross School has been enlarged that school can take up to 90 children and there are at present vacancies for 14 pupils. In addition, by the standards elsewhere in the County, there are at least a dozen children who could be dealt with fairly well in the ordinary schools. Thus a total of 25 or more places could be made available for the education of more severely physically handicapped pupils from other parts of the County if residential accommodation were available.

The Committee might wish to consider the provision of a hostel for such children. The present medical room is inadequate and it would also be necessary to build a new treatment room and to employ the physiotherapist on a full-time basis.

Educationally Sub-Normal

The Educationally sub-normal children are the most numerous amongst the categories of handicapped pupils. In general provision is a matter for each authority and there was little discussion at the Regional meetings.

Despite the extra provision made for such children, there was at the end of year a waiting list of 300 children recommended for special schooling. In about two thirds of cases the parents

had refused consent, the majority doubtless solely because they didn't wish their children to leave home.

Even so the picture is not complete for Medical Officers tend not to "ascertain" younger children when they know there is no provision for those under 9, nor older boys when they realise that with the long waiting list there is little possibility of a place being found before the boy is due to leave school.

Long waiting lists also have adverse effects on the parents as recounted by Dr. Rogers:—

"The scarcity of vacancies for more prompt admission of these children to special schools is frustrating because I find that in some cases where the parents have at first agreed to the children entering such a school, by the time a vacancy occurs, the parents have changed their minds."

Several Medical Officers comment on difficulties caused by lack of suitable provision. Dr. Hinde writes:—

"The Educationally Sub-normal children and those of a low I.Q. present a much more difficult problem. In the one or two teacher schools—the majority of my Primary Schools—it is very difficult for the children to have all the help they need, without seriously depriving the more average children. Over the age of 11 years i.e. in the larger schools, the E.S.N. child is able to get special attention in backward classes. The number able to go to Special Schools is regrettably small, but in so conservative a rural area, even if more residential places were available it is doubtful if the children would be allowed to go, the parents being, generally, those least able to see what is to the best interest of their children." Dr. Budding says:—

"These children are the biggest problem of all, partly because there are so many of them. A large number are ascertained, out of those a very small percentage go to special schools.

The Education Development plan includes provision for day E.S.N. pupils both in Torquay and Barnstaple. If such schools could be provided soon the majority of the E.S.N. children in these areas could be educated as day pupils, incidentally at lower cost, but most important of all, releasing places at the residential schools which could be taken up by children living in the more rural areas where no form of day provision is possible.

The provision of a special class in Newton Abbot is an interesting experiment and Dr. R. Walker has in mind similar arrangements in his area when he says:—

"It is sometimes difficult to arrange special educational treatment for children who although backward are not ascertainable as E.S.N. It does seem that there would be a definite advantage in

having in one of the Plympton Primary Schools a special class for these children, drawing its pupils from all the primary schools in the district."

Dr. Green has for several years advocated a scheme (somewhat similar to Dr. Davidson's for physically handicapped pupils) whereby the younger E.S.N. children would be brought into one of the primary schools in the same town as the secondary modern school for the area. They would travel on the buses already provided for older pupils but could be taught in special classes.

This system might be a valuable one in areas where a day special school is out of the question but where the school population in the catchment area would justify special classes.

Maladjusted

For the majority of maladjusted children who require a period of residential care, the Crichel and Gables hostels have proved adequate. Concern has been felt by members of the Child Guidance Teams (and also by the Probation Officers and Children's Visitors) over a relatively small number of older children—particularly girls—who are approaching school leaving age and are not ideally suited for the Gables.

The Underwood report suggested that Education Authorities should be empowered to provide residential care and help for such children up to the age of 18, but it is not easy to know what else can be done pending legislation.

OAKLANDS PARK

Children spent periods of about three months convalescing at the Oaklands Park home during the year. The benefit gained is well summarised in this excerpt from Dr. D. MacTaggart's report:—

"I should also like to mention how valuable I found the facilities afforded by the County Council at Oaklands Park, Dawlish. The children from this area who have gone there have without exception, returned in better health, and have without, exception, been very happy during their stay, and the parents, even those who were doubting, and reluctantly gave permission, have all been high in their praise for this home and the beneficial results which it produces."

SCHOOL HYGIENE

Further progress has been made in the provision of hand washing facilities this year. Dr. Hinde reports:—

"Hand washing facilities, cold water, towels and soap are now available in all schools and at meals young children's hand washing is generally supervised by the staff. Hot water is not always available, but I don't think it is important as the children are hardy country children."

Even though the children may be hardy I nevertheless feel that hot water is highly desirable and am interested in the comment of Dr. Archer, who says:—

“A number of my smaller schools have been provided with hot water in the cloakrooms this year. This is very much appreciated by both staff and children and will, I am sure, result in an improvement in school hygiene.”

I feel that the aim should be to provide hot water to all hand-washing basins, and that certainly no new basins should be installed fitted with cold water only. As Dr. Vernon remarks:—

“Now that so many schools have electricity with electrically heated water for the canteen, could not this hot water be laid on to the wash-hand basins, say, just before school dinners so that the children can wash their hands before dinner, and again after the canteen workers have washed up? It appears to me that this could be done easily and with very little extra expense.

Hand washing facilities vary in school to school from the Grammar School with plenty of hot water, towels and soap to the Primary School in the country where hand-washing is “difficult” because all water has to be carried from the village by hand.”

Dr Anderson also finds great variations:—

“In these days when one is anxious to inculcate into the minds of young children the great need for personal hygiene, it is essential in my opinion that adequate number of wash-hand basins with hot and cold water should be provided for the children. Again in the Exmouth Schools the standard of wash-hand basins provision varies tremendously—more modern schools are adequately equipped; and the older schools may have wash-hand basins but no hot water.”

Soap is as necessary as hot water, but there are difficulties such as the following:—

“Soap is provided but has a habit of disappearing. It is frequently used as a missile! Once the allotment for the week is gone, no more is forthcoming.”

Special liquid soap dispensers which deliver only a fixed amount at one time would overcome such difficulties.

Dr. Kingdon comments further:—

“Roller towels are provided in adequate number, and changed as frequently as supplies permit. Needless to say they get very dirty very quickly. It is very difficult to wash knees in a hand basin; it is comparatively easy to clean them on the towel! In some schools children are encouraged to bring their own towels, but unless there are lockers provided they tend to get lost or mixed up.”

Dr. Budding reports:—

“A large number of schools either have hygienic paper towels, or the children bring their own, Once either of these is organised

the teachers too find it easier, and also cheaper.”

Dr. Walker also favours paper towels:—

“Hand drying facilities vary greatly. At some schools the children bring their own towels which are hung on separate hooks, at others roller towels are provided. At another, paper towels prove to be very successful. My own opinion is that paper towels are almost as cheap as roller towels once the novelty has worn off, and by far the most hygienic of hand drying methods.”

Toilet facilities come in for some criticism from him:

“In practically all the village schools the sanitary conveniences are situated in outside buildings very liable to freeze, and to be out of use for some time.

“The urinals for boys are mostly rendered concrete, exceptionally difficult to keep in a clean condition and free from smell. In only one country school have I seen glazed urinal slabs.”

Dr. Epstein mentions that girls are maturing at an early age and that this is another difficulty associated with inadequate sanitary accommodation—as she says “open toilets are alright for younger children but the older girls in primary schools must be catered for.”

Dr. Anderson mentions that in his area the small number of girls in primary schools who have commenced to menstruate are catered for by being allowed to use the staff toilet and sanitary bin.

He continues:—

With regard to the disposal of the Sanitary Towels at the Senior schools, both the Grammar and Secondary Modern Girls schools make use of an incinerator, (gas in the Grammar School and an electric incinerator at the Girls Secondary Modern School) and whilst some of the girls do make use of the electric incinerator, the complete disposal of one Sanitary Towel takes 10 minutes which seems that one such apparatus is not sufficient for the needs. The question of the use of Sanitary bins has been discussed with the Headmistress and whereas it is quite convenient for that method to be used in wintertime when the boiler fires are on, some difficulty is found to dispose of the contents of the bins in summertime when there are no such fires in use.

Dr. Epstein also finds that “a great many adolescent girls, although well developed physically, have no knowledge of the significance of the change in their bodies.” She also encounters disorders of menstruation such as oligomenorrhoea, hypomenorrhoea and, “more distressing still menorrhagia and severe dysmenorrhoea. It was obvious that very few of these girls had consulted their family doctor and equally few had discussed the facts with their mothers. These girls have to be allowed time and be encouraged to talk—they cannot be rushed and consequently one cannot possibly see the numbers that one expects to complete in a session with younger children.”

As she points out privacy for such discussion is essential but often impossible to obtain with accommodation available in some schools. She describes trying to work “under difficult conditions in a cloakroom, with 2 girls at a time dressing and undressing in a W.C. off the room I used: the girls had to walk through the cloakroom on the way in and out as no other room was available.”

SCHOOL MEALS

The School Medical Officers continue to pay periodic visits to canteens. One comments “School meals remain popular in spite of the increase in price. In one or two of the larger Canteens there has been a very great improvement in the variety of the menus and in the way the food is served during the year.”

Dr. Walker reports similarly:—

“The meals provided maintain a very high standard and it does appear that on the whole better meals are had when they are cooked on the premises than when they are transported from a central kitchen.

There is need of redecoration and improvement of equipment in some of the schools, although some have recently been modernised.”

Other Medical Officers comment on difficulties caused by condensation in the kitchen, leading to distemper flaking off and falling down onto food preparation surfaces. An increasing amount of paint is being used instead of distemper and may solve the trouble.

An outbreak of food poisoning at a school in North Devon (due not to lack of hygiene in the canteen but to imperfectly processed tinned peas) is described on page 8.

School Milk

This year we achieved a record in that all milk supplied to schools was either Tuberculin Tested or Pasteurised. The remarkable progress made over the past 10 years is shown in the table below:—

<i>Year</i>	<i>Accredited</i>	<i>Non-designated</i>	<i>Dried</i>	<i>Tuberculin Tested</i>	<i>Pasteurized</i>	<i>Total Schools</i>
1947	106	119	17	109	139	510
1948	92	116	25	95	165	493
1949	20	58	13	143	245	479
1950	16	48	9	163	235	471
1951	17	34	4	163	244	462
1952	15	38	3	156	245	457
1953	6	19	1	162	275	463
1954	—	4	7	139	317	467
1955	—	4	5	98	360	467
1956	—	—	—	23	446	469

Regular tests are made on all school milks, with special attention to those taking raw Tuberculin Tested milk.

PHYSICAL EDUCATION

Dr. Rogers states in his report that “ bad posture in adolescent children of both sexes continues to be too frequent in spite of the keen co-operation of School P.T. staff and Health Visitors. I suspect that parents and the children themselves do not persevere with the exercises at home, in spite of my ceaseless urging.”

It is hoped that this difficulty will be eased when special printed leaflets with diagrams are available. Such exercises were further discussed with Mr. N. Capener during the year.

These exercises will, it is hoped, be supervised at school by the Physical Education teachers, and at home by parents with the aid of the leaflet.

Dr. Walker writes:—

“ There appears to be adequate provision of playing fields in this district but there is great need of a swimming bath. If there were all the year round swimming facilities in this district three to four thousand children would be served.

The only facilities available are in Plymouth, which necessitates a journey of several miles through the centre of the City and causes the waste of a considerable amount of time. A large and therefore expensive bath would not be necessary. Its chief function would be to teach children to swim. Money now spent on occasional bus journeys to swim in Plymouth could possibly be used in defraying part of the cost of building a pool locally.

It can be argued that we have a sea coast and bathing should be easy for the children. It is easy and pleasant when they can swim but unsuitable for teaching swimming, and requires travelling to reach a suitable place. In a district such as this with a long sea coast, I feel it is most important that children should learn to swim before they leave school.”

All the School Medical Officers have commented on the help and co-operation received from teachers during the year. In conclusion, I should like to add a word of appreciation to the Chief Education Officer and other members of his department who have also done so much to assist us.

STAFF OF THE MEDICAL DEPARTMENT. Appendix I.

County Medical Officer and Principal School Medical Officer.

W. J. Doyle, M.B., B.Ch., B.A.O., D.P.H., B.Sc., L.M.

Deputy County Medical Officer and Deputy Principal School Medical Officer.

D. E. Cullington, M.A., M.B., B.Chir., D.C.H., D.P.H.

Senior Assistant Medical Officer for Maternity and Child Welfare.

F. Gloria Richards, M.R.C.S., L.R.C.P., D.(Obst.) R.C.O.G

Medical Adviser in Mental Health.

Christina J. McLeay, M.B., Ch.B. (Edinburgh) (to 15.2.1956)

County Psychiatrist

W. Hinds, L.M.S.S.A., M.B., B.S., D.P.M. (from 1.7.1956.)

Psychiatrist (Part-time)

H. S. Gaussen, M.R.C.S., L.R.C.P.

Senior County Dental Officer and Principal School Dental Officer.

J. Fletcher, L.D.S.

County Superintendent of Nursing and Supervisor of Midwives.

Miss L. Reynolds, S.R.N., S.C.M., H.V.C.

Superintendent Health Visitor

Miss M. Kelly, S.R.N., S.C.M., H.V.C. (from 1.8.1956)

County Sanitary Officer: M. S. Powling, C.R.S.I., M.S.I.A.

Chief Clerk: H. T. Baldwyn.

County Ambulance Officer: C. H. Congdon.

Home Help Organiser: G. P. Brooks, D.P.A., D.S.A.

Senior Social Workers.

Mental Deficiency:—Miss J. H. MacMichael.

Mental Health:—Mr. L. H. Jenkins, D.S.S., M.H.Cert.

Senior Occupational Therapist, Miss M. M. Keily, M.A.O.T.

Assistant County Medical Officers/School Medical Officers.

L. G. Anderson, M.D., Ch.B., D.P.H.	}	Mixed Appointments
H. M. Davies, M.A., M.R.C.S., L.R.C.P., D.P.H.		
D. K. MacTaggart, M.A., M.B., Ch.B., D.P.H.		
R. B. Walker, M.R.C.S., L.R.C.P., D.P.H.		
N. E. R. Archer, M.A., D.M., B.Ch., D.P.H.		
M. E. Budding, B.Sc., M.B., B.Ch., D.P.H.		
T. J. Davidson, M.B., Ch.B., D.P.H., D.T.M.&H.		
D. M. Green, M.B., B.S., M.R.C.S., L.R.C.P., D.P.H.		
M. H. King, M.B., Ch. B., D.P.H. (to 31.8.56)		
J. S. Rogers, L.R.C.P., M.R.C.S.		
N. Proctor-Sims, M.R.C.S., L.R.C.P., M.R.C.O.G.		
L. Solomon, B.A., M.B., B.Ch., B.A.O., L.M., D.P.H., D.C.H.		
H. R. Vernon, T.D., M.B., Ch.B.		
G. H. Walker, M.B., Ch.B., D.P.H.		
J. M. Hinde, M.A., B.M., B.Ch., D.R.C.O.G. (part-time).		
M. C. H. Kingdon, M.B.E., M.A., M.B., B.Ch., M.R.C.S., L.R.C.P. (part-time).		
M. R. Epstein, L.R.C.P.I. & L.M., L.R.C.S.I. & L.M., D.C.H. R.C.S.I. (part-time).		
J. M. MacTaggart, M.B., Ch. B., D.P.H. (part-time)		

School Ophthalmic Surgeons.

(on staff of the Regional Hospital Board)

M. L. Foxwell, M.R.C.S., L.R.C.P., D.P.H., D.C.H.
W. G. Hutton, M.A., M.R.C.S., L.R.C.P., D.O.M.S.

Chest Physicians.

G. E. Adkins, M.B., B.Chir. (Cantab.)
W. E. B. Lloyd, M.R.C.S., L.R.C.P., D.P.H.
A. J. McMillan, M.R.C.S., (Eng.), L.R.C.P. (Lond.)
J. C. Mellor, M.B., B.Ch.

The Chest Physicians are on the staff of the Regional Hospital Board, but a portion of their time is devoted to prevention, care and after-care, which remains the responsibility of the County Health Committee.

County Dental Officers/School Dental Officers.

G. Baker, L.D.S., R.C.S. (to 21.12.56)
A. T. Dally, L.D.S.
G. C. Derbyshire, L.D.S.
J. L. Dickson, L.D.S. R.F.P.S.

T. L. Fiddick, L.D.S. (part-time)
H. W. Gibbs, L.D.S., R.C.S.
K. W. Massey, L.D.S.
W. R. Matthews, L.D.S., R.C.S. (part-time).
A. S. Peacock, L.D.S., D.D.O. (also part-time Orthodontist).
W. H. Phillips, L.D.S.
J. A. Pugh, L.D.S. (part-time).
G. Reed, L.D.S. (dec'd 2.4.56)
B. J. Shapland, L.D.S.
B. M. Simpson, L. D. S., R.C.S. (to 31.12.56)
J. E. B. Smith, L.D.S., R.C.S.
J. M. Steer, L.D.S., R.C.S.
J. K. Vowles, B.D.S.
F. M. Warren, B.D.S., L.D.S., R.C.S.
P. F. G. Whitfield, L.D.S., (also part-time Orthodontist)

APPENDIX II

MEDICAL OFFICERS OF HEALTH

<i>Area</i>	<i>District Councils</i>		<i>Medical Officers of Health</i>
1	B. Salterton Exmouth St. Thomas	U.D. U.D. R.D.	L. G. Anderson, M.D., M.B., Ch.B., D.P.H.
2	Ottery St. Mary Sidmouth Honiton Seaton Axminster Honiton	U.D. U.D. M.B. U.D. R.D. R.D. }	R. R. Trail, M.A., M.B., B.Ch., M.R.C.S., L.R.C.P. E. L. Perry, D.S.O., M.R.C.S., L.R.C.P., D.P.H. D. Steele-Perkins, L.R.C.P., L.R.C.S., L.R.F.P.S.
3	Crediton Crediton Tiverton Tiverton	U.D. R.D. M.B. R.D. }	N. F. Sawers, M.B., Ch.B. L. N. Jackson, D.M., B.A., M.B., B.Ch. G. Nicholson, M.D., D.P.H., F.R.C.S.
4	Barnstaple Barnstaple South Molton South Molton Ilfracombe Lynton	M.B. R.D. M.B. R.D. U.D. U.D.	F. J. H. Martin, M.R.C.S., L.R.C.P., D.P.H. A. H. Morley, O.B.E., M.B., Ch.B., F.R.C.S., D.P.H. M. P. Nightingale, M.R.C.S., L.R.C.P.
5	Northam Bideford Gt. Torrington Holsworthy Bideford Torrington Holsworthy	U.D. M.B. M.B. U.D. R.D. R.D. R.D.	C. J. Carey, M.R.C.S., L.R.C.P. C. F. R. Briggs, M.B., B.S., M.R.C.S., L.R.C.P. S. Craddock, M.B., B.S., M.R.C.S., L.R.C.P. N. B. Betts, M.B., B.Chir., F.R.C.S., M.R.C.S., L.R.C.P. E. H. Walker, M.R.C.S., L.R.C.P., M.B., B.S. C. W. Evans, M.R.C.S., L.R.C.P.
6	Okehampton Tavistock Broadwoodwidge Okehampton Tavistock	M.B. U.D. R.D. R.D. R.D. }	E. D. Allen-Price, M.D., M.B., Ch.B., D.P.H.
7	Salcombe Kingsbridge Kingsbridge Plympton St. Mary	U.D. U.D. R.D. R.D. }	R. B. Walker, M.R.C.S., L.R.C.P., D.P.H.

MEDICAL OFFICERS OF HEALTH—continued

<i>Area</i>	<i>District Councils</i>		<i>Medical Officers of Health</i>
8	Dawlish Newton Abbot Teignmouth Newton Abbot	U.D. U.D. U.D. R.D. }	H. M. Davies, M.A., M.R.C.S., L.R.C.P., D.P.H.
9	Torquay	M.B.	J. V. A. Simpson, M.D., M.B., B.S., M.R.C.S., L.R.C.P., D.P.H.
10	Totnes Ashburton Buckfastleigh Totnes	M.B. U.D. U.D. R.D.	Elizabeth Davies, M.B., Ch.B., M.R.C.S., L.R.C.P., D.P.H. R. Bellamy, M.B., B.Chir., M.R.C.S., L.R.C.P. E. C. Ironside, M.A., M.B., Ch.B. S. C. Jellicoe, M.R.C.S., L.R.C.P. (to 4.8.56) E. M. K. Jellicoe, M.R.C.S., L.R.C.P. (from 5.8.56)
11	Dartmouth Brixham Paignton	M.B. U.D. U.D. }	D. K. MacTaggart, M.A., M.B., Ch.B., D.P.H.

TABLE I (A)

MASS RADIOGRAPHY SERVICE

ANALYSIS OF EXAMINATIONS COMPLETED

	Miniature Films	Recalled for Large Films	Failed to attend for Large Films	Normal Large Films	Total Abnor- malities detected	Non- Tubercu- lous con- ditions	Active Tubercu- losis	Incidence % Active Tubercu- losis	Suspected Tubercu- losis (Under Obs.)	Inactive Tubercu- losis	Being Investi- gated
									No.	%	
Male	15973	1111	33	342	733	379	22	.137%	125	.782	3
Female	15588	805	22	262	519	266	14	.080%	97	.622	2
Total:—	31561	1916	55	604	1252	645	36	.114%	222	.703	5

TABLE 1 (B)

DETAILS OF CENTRES VISITED BY UNITS 10C. & 10E.

1956 Date	Centre	Unit	Male	Female	Total
Jan. 2	Western Lodge, CREDITON	(E)	4	106	110
„ 4—6	Langdon Extension, DAWLISH	(E)	298	213	511
„ 17—20	Starcross Hospital	(E)	482	213	695
„ 25—1	BRIXHAM	(E)	361	439	800
Feb. 7—10	DARTMOUTH	(E)	372	426	798
„ 15—20	SALCOMBE	(E)	213	336	549
„ 21—27	KINGSBRIDGE	(E)	467	422	889
Mar. 6	Centrax Factory, NEWTON ABBOT	(E)	326	32	358
„ 7—19	School Canteen, NEWTON ABBOT	(E)	1355	1205	2560
„ 20—26	TEIGNMOUTH	(E)	408	371	779
„ 27—29	Stover Hostel, NEWTON ABBOT	(E)	239	252	491
Apr. 4	Torbay Hospital, TORQUAY	(E)	43	251	294
„ 5—9	OTTERY ST. MARY	(E)	350	426	776
„ 11—17	SIDMOUTH	(E)	399	523	922
„ 16—18	H.M. Prison, DARTMOOR	(C)	676	—	676
„ 19—23	Town Hall, PRINCETOWN	(C)	92	143	235
„ 24—25	TAVISTOCK	(C)	214	197	411
May 1—9	St. Luke's Hall TORQUAY	(E)	1011	1339	2350
„ 10—11	BEER	(E)	208	264	472
„ 14—18	SEATON	(E)	421	714	1135
„ 22—28	St. Marychurch, TORQUAY	(E)	503	505	1008
Jun. 12	Technical School, BARNSTAPLE	(E)	186	201	387
„ 14—19	SOUTH MOLTON	(E)	294	316	604
„ 20—21	BRAUNTON	(E)	121	200	321
„ 25	Secondary Modern School, PLYMSTOCK	(C)	241	210	451
„ 25—2	BARNSTAPLE	(E)	996	595	1591
Jul. 3—9	HOLSWORTHY	(E)	374	363	737
„ 10—11	North Devon Clay Co. TORRINGTON	(E)	53	—	53
„ 6—7	English Clays, PLYMPTON	(C)	69	5	74
„ 12—18	BIDEFORD	(E)	740	1053	1793
„ 19—20	Torridge Vale Dairies, BIDEFORD	(E)	232	20	252
„ 23—26	TORRINGTON	(E)	289	337	626
„ 30—3	TIVERTON	(E)	245	216	461

TABLE 1 (B)

DETAILS OF CENTRES VISITED BY UNITS 10C & 10E (Cont.)							
1956							
<i>Date</i>		<i>Centre</i>			<i>Male</i>	<i>Female</i>	<i>Total</i>
Aug. 13—16		Moorhaven Hospital, IVYBRIDGE	..	(E)	408	358	766
Nov. 5—9		OKEHAMPTON	..	(E)	381	271	652
„ 12		Wiggins & Teape, BRADNINCH	..	(E)	26	6	32
„ 13—22		HONITON	..	(E)	1583	1748	3331
Nov. 23—6		EXMOUTH	..	(E)	960	1100	2060
Dec. 7		All Hallows School, ROUSDON	..	(E)	296	40	336
„ 27—31		Torbay Hospital, TORQUAY	..	(E)	37	178	215
TOTAL:					15973	15588	31561

TABLE II

CHEST HOSPITALS. DISEASE CLASSIFICATION ON ADMISSION

	Classification	† Hawkmoor				‡Torquay Isolation Hospital Males only	Hawley		
		Males	Females	Children	Total		Males	Females	Children
Pulmonary	Non-Tuberculous Thoracic Surgical Observation Mass Radiography)*	182	127	47	356	—	—	—	—
	(Not ,)	14	14	—	28	—	—	—	—
	Class R.A.1.	47	28	5	80	2	—	—	—
	" R.A.2.	12	8	2	22	6	4	1	—
	" R.A.3.	1	3	1	5	1	1	1	—
	" R.B.1.	3	2	—	5	—	—	—	—
	" R.B.2.	24	29	1	54	1	5	4	—
	" R.B.3.	36	24	—	60	8	2	5	2
	Class N.R.A.	46	29	—	75	1	5	2	—
	" N.R.B.	—	1	—	1	—	1	—	—
Non-Pulmonary		2	6	1	9	1	3	2	—
	TOTAL	367	271	57	695	20	21	15	2
									38

†Tuberculous admissions include three cases from Plymouth and two from Cornwall.

*4 M.M.R. cases subsequently found to have T.B. and included in T.B. figures.

‡10 months to 31st October, 1956.

Abbreviations:

- R.A. —tuberculosis negative (pulmonary)
R.B. —tuberculosis positive (pulmonary)
N.R.A.—tuberculosis negative (non-pulmonary)
N.R.B.—tuberculosis positive (non-pulmonary)
Numbers—stages of disease

TABLE III

The following Table gives the birth weight place of birth, and the number of premature babies surviving in each group at the end of 28 days.

Weight at Birth	PREMATURE LIVE BIRTHS. Total Notified 374.															PREMATURE STILL-BIRTHS			
	Born in Hospital				Born at Home and Nursed entirely at Home				Born at Home and transferred to hos- pital on or before 28th day				Born in Nursing Home and trans- ferred to hospital on or before 28th day				TOTAL NOTIFIED 64		
	Total	Died with- in 24 hrs. of birth	Sur- vived 28 days	Total	Died with- in 24 hrs. of birth	Sur- vived 28 days	Total	Died with- in 24 hrs. of birth	Sur- vived 28 days	Total	Died with- in 24 hrs. of birth	Sur- vived 28 days	Total	Died with- in 24 hrs. of birth	Sur- vived 28 days	Born in Hos- pital	Born at Home	Born in Nurs- ing Home	
3lb 4oz. or less	24	9	7	3	3	8	8	—	—	—	—	—	—	—	—	21	7	—	
Over 3lb. 4ozs. up to and including 4lb. 6ozs.	57	6	38	9	2	9	9	—	—	—	—	—	—	—	—	14	4	1	
Over 4lb. 6oz. up to and including 4lb. 15oz.	63	2	56	6	—	6	6	—	—	—	—	—	—	—	—	4	3	—	
Over 4lb. 15oz up to and including 5lb 8oz.	118	—	116	56	3	53	11	—	—	3	—	3	1	—	1	7	2	1	
TOTALS	262	17	217	74	8	66	34	8	25	3	—	3	1	—	1	46	16	2	

TABLE IV

(A) LUNACY AND MENTAL TREATMENT ACTS**ADMISSIONS TO HOSPITALS**

Certified Cases	(Section 16, Lunacy Act, 1890)	..	..	..	39
"	(Private)	..	..	..	nil
Voluntary Cases	(Section 1, Mental Treatment Acts, 1930)	..	..	..	637
"	(Private)	..	..	..	17
Temporary Cases	(Section 5, Mental Treatment Acts, 1930)	..	..	..	1
"	(Private)	..	..	..	nil
Other Cases	(Section 11, Lunacy Act, 1890)	..	..	..	nil
"	(Section 20, Lunacy Act, 1890)	..	..	..	303
"	(Section 21, Lunacy Act, 1890)	..	..	..	16
"	(Section 26, Magistrates' Court Act, 1952)	..	..	..	1
Total number of admissions	..	..	..	..	1,014
Number of Social Workers visits entailed	..	..	..	..	3,042

DISCHARGED FROM HOSPITALS

Number of Devon County patients who were discharged from Mental Hospitals	..	..	..	..	646
Number of Devon County patients who have died	..	..	..	..	179

PSYCHIATRIC OUT-PATIENT CLINICS

Number of appointments for Psychiatric Clinics	..	..	..	..	242
Number of cases who attended as Out-Patients	..	..	..	..	132

SOCIAL WORKERS OTHER ACTIVITIES**(i) AFTER-CARE OF PATIENTS DISCHARGED**

Number of After-Care visits made during the year	..	..	..	..	3,439
Present number of patients receiving periodical After-Care	..	..	..	..	555

(ii) ADVISORY CASES

Number of cases in which advice has been given	..	..	..	..	826
Visits and interviews entailed	..	..	..	..	1,354
Number of cases where guidance is still required	..	..	..	..	46

(B) MENTAL DEFICIENCY

Place of Safety Certificates issued	..	..	..	..	..	6
Place of Safety Certificates withdrawn	..	..	..	..	..	1
Total remaining under Place of Safety	..	..	..	..	..	1
Number of patients in respect of whom Certification Orders were made	..	..	..	..	..	38
Number of patients who were transferred	..	..	..	..	..	3
Number of patients discharged from the provisions of the Acts	..	..	..	..	..	72
Number of patients who have died	..	..	..	..	..	17
Number of patients who absconded	..	..	..	..	..	13
Number of patients apprehended	..	..	..	..	..	11
Number of patients under Guardianship	..	..	..	..	..	52
Devon Cases (In County)	..	..	..	..	..	35
Devon Cases (Out County)	..	..	..	..	..	6
Other Authorities' Cases resident in Devon and supervised by the Mental Health Section	..	..	..	..	..	11
Number of Devon County Certified Mental Defectives at present on Licence from Institutions	..	..	..	..	..	92
(Comprising 49 Males and 43 Females)						
Number of Other Authorities' Certified Mental Defectives resident in the County of Devon on Licence, and supervised by the Mental Health Section	..	..	..	..	..	2
(Comprising 2 Females)						

On the 31st December, 1956, the total number of cases under Order, including Guardianship cases amounted to	980
Number of Devon County Certified Mental Defectives due for re-consideration in respect of whom Home Condition Reports were submitted	182
Number of Other Authorities' Certified Mental Defectives whose homes are now in the County of Devon, in respect of whom Home Condition Reports were submitted	26
Number of patients placed under Statutory Supervision	61
Number of patients removed from Statutory Supervision	74
Total number of patients remaining under Statutory Supervision (Comprising 238 Males and 198 Females)	436
Total number of patients under Voluntary Supervision (Comprising 184 Males and 190 Females)	374
On the 31st December, 1956, the total number of pupils receiving Home Teaching was	104
Number of lessons given	2,325

	<i>Pupils</i>	<i>Lessons</i>
Area No. 1. E. Devon	34	663
„ No. 2. N. Devon	41	882
* „ No. 3. W. Devon	—	81
„ No. 4. S. Devon	29	699
	104	2,325

*The Home Teacher for No. 3 Area, who commenced duties on 2nd January, 1956, resigned and terminated her appointment on the 30th April, 1956—consequently, the 26 pupils on her list were not receiving Home Teaching on the 31st December, 1956. No successor for this Area has yet been appointed. On the 31st December, 1956, the number of pupils attending the Occupation Centres amounted to

Number of sessions held	1,479
Number of attendances	15,692

	<i>Pupils</i>	<i>Sessions</i>	<i>Attendances</i>
BARNSTAPLE	20	375	5,359
† EXETER	7	390	2,123
‡ ILMINSTER	1	—	—
PLYMSTOCK	9	344	2,943
TORQUAY	24	370	5,267

† By arrangement with the Exeter City Local Health Authority

‡ One child from Axminster attends the Ilminster Occupation Centre daily by arrangement with the Somerset County Council.

During the year the number of medical examinations of patients of all types was 108
These examinations were carried out by:—

Dr. Christina J. McLeay	37	(Resigned 15.2.56)
Dr. H. Scott-Forbes	17	(Temporary—Part-time)
Dr. W. Hinds	54	(Commenced 2.7.56)

The number of defectives Notified by the Education Committee under Section 57 of the Education Act, 1944, was 81
Under Sub-Section (3) 40
„ „ „ (4) nil
„ „ „ (5) 41

There were no Cancellation of Section 57 Reports—Education (Miscellaneous Provisions) Act, 1948.

Number of visits made in connection with all types of Defectives .. 3,663
Number of patients awaiting Institutional Care 37
(Comprising 24 Males and 13 Females)

TABLE V
School Medical Inspections, 1946-56

Year	No. on Register	Periodic Examinations						Special Examinations	Reinspections
		Entrants 5 years	8 years	10 years	12 years	Leavers	Total		
1946	49,427	6,970	*	3,154	+(4,126)	1,917	16,167	20,956	46,803
1947	52,329	7,811	*	2nd Age Gp. 4,077	+(4,966)	1,823	18,677	18,696	42,949
1948	53,537	7,370	*	4,360	+(6,833)	1,718	20,281	21,125	47,562
1949	54,434	6,719	*	4,111	+(8,275)	1,303	20,408	17,350	40,658
1950	54,955	6,551	*	4,064	+(7,095)	2,218	19,928	16,117	37,628
1951	57,084	6,637	242	4,246	4,198	4,293	19,616	15,439	34,705
1952	59,272	7,723	204	5,006	4,282	4,158	21,373	15,829	35,242
1953	60,717	7,746	361	5,459	4,425	4,525	22,516	14,174	33,876
1954	62,134	7,003	305	5,232	4,440	4,530	21,510	16,616	36,385
1955	63,966	6,554	326	6,289	5,385	4,506	23,060	‡658	‡15,184
1956	64,928	6,102	516	5,873	5,542	4,856	22,889	‡550	‡13,863

* These figures are not available separately.

+ These figures are for "other periodic examinations" and include these relating to 8 year olds.

‡ Clinic cases not included

Table VI

A.—PERIODIC MEDICAL INSPECTIONS

Age Groups inspected and Number of Children examined in each:

Entrants	..	..	..	..	..	6,102
Second Age Group	..	..	..	..	..	5,873
Third Age Group	..	..	..	..	..	4,856
						<hr/>
TOTAL						16,831
Additional Periodic Inspections†	..	..	..	..	..	6,058
						<hr/>
GRAND TOTAL						22,889

B.—OTHER INSPECTIONS

Number of Special Inspections	..	..	..	..	550
Number of Re-Inspections	..	..	..	..	13,863
					<hr/>
TOTAL					14,413

C.—PUPILS FOUND TO REQUIRE TREATMENT

Number of Individual Pupils found at Periodic Medical Inspection to Require Treatment (excluding Dental Diseases and Infestation with Vermin).

- NOTES.—(1) Pupils found at Periodic Medical Inspection to require treatment for a defect should not be excluded from this return by reason of the fact that they are already under treatment for that defect.
- (2) No individual pupil should be recorded more than once in any one column of this Table and therefore the total in column (4) will not necessarily be the same as the sum of columns (2) and (3).

<i>Age Groups Inspected</i> (1)	<i>For defective vision (excluding squint)</i> (2)	<i>For any of the other conditions recorded in Table VII</i> (3)	<i>Total individual pupils.</i> (4)
Entrants	27	392	412
Second Age Group	43	275	310
Third Age Group	97	189	271
<hr/>			
Total	167	856	993
Additional Periodic Inspections†	80	305	370
<hr/>			
Grand Total ..	247	1161	1363

†E.G., Children at special schools or who missed the usual periodic examination.

Table VII

A.—RETURN OF DEFECTS FOUND BY MEDICAL INSPECTION IN
THE YEAR ENDED 31st DECEMBER, 1956

NOTE:—All defects noted at medical inspection as requiring treatment are included in this return, *whether or not this treatment was begun before the date of the inspection.*

Defect Code No.	Defect or Disease (1)	PERIODIC INSPECTIONS		SPECIAL INSPECTIONS	
		No. of defects		No. of defects	
		Requiring treatment	Requiring to be kept under observation but not requiring treatment.	Requiring treatment	Requiring to be kept under observation but not requiring treatment.
		(2)	(3)	(4)	(5)
4	Skin	180	369	12	14
5	Eyes— <i>a.</i> Vision ..	247	99	15	2
	<i>b.</i> Squint ..	78	72	4	1
	<i>c.</i> Other ..	72	97	2	7
6	Ears— <i>a.</i> Hearing ..	47	288	12	14
	<i>b.</i> Otitis Media	36	188	3	10
	<i>c.</i> Other ..	9	53	1	4
7	Nose or Throat ..	193	898	27	37
8	Speech	65	175	20	13
9	Lymphatic Glands ..	24	755	3	23
10	Heart	30	246	9	15
11	Lungs	50	374	20	16
12	Developmental—				
	<i>a.</i> Hernia ..	12	35	1	1
	<i>b.</i> Other ..	19	242	4	7
13	Orthopaedic—				
	<i>a.</i> Posture ..	78	516	19	7
	<i>b.</i> Feet ..	106	298	4	2
	<i>c.</i> Other ..	140	505	24	23
14	Nervous system—				
	<i>a.</i> Epilepsy ..	7	29	—	4
	<i>b.</i> Other ..	28	85	8	7
15	Psychological—				
	<i>a.</i> Development	18	123	4	7
	<i>b.</i> Stability ..	26	246	5	21
16	Abdomen	3	3	—	—
17	Other	55	255	14	19

B.—CLASSIFICATION OF THE GENERAL CONDITION OF PUPILS
INSPECTED DURING THE YEAR IN THE AGE GROUPS

<i>Age Groups Inspected</i>	<i>No. of Pupils Inspected</i>	Satisfactory		Unsatisfactory	
		<i>No.</i>	<i>% of col 2</i>	<i>No.</i>	<i>% of col 2</i>
(1)	(2)	(3)	(4)	(5)	(6)
Entrants	6102	6000	98.32	102	1.67
Second Age Group	5873	5799	98.74	74	1.26
Third Age Group	4856	4815	99.15	41	.84
Additional Periodic Inspections	6058	5944	98.11	114	1.88
Total	22889	22558	98.55	331	1.44

Table VIII

INFESTATION WITH VERMIN

(i) Total number of examinations in the schools by the school nurses or other authorized persons	179,956
(ii) Total number of <i>individual</i> pupils found to be infested ..	431
(iii) Number of individual pupils in respect of whom cleansing notices were issued (Section 54 (2), Education Act, 1944) ..	184
(iv) Number of individual pupils in respect of whom cleansing orders were issued (Section 54 (3), Education Act, 1944) ..	9

TABLE IX

TREATMENT OF PUPILS ATTENDING MAINTAINED PRIMARY AND SECONDARY SCHOOLS (INCLUDING SPECIAL SCHOOLS)

GROUP 1.—EYE DISEASES, DEFECTIVE VISION AND SQUINT

	<i>Number of cases dealt with</i>	
	<i>by the Authority</i>	<i>otherwise*</i>
External and other, excluding errors of refraction and squint	—	292
Errors of refraction (including squint)	—	11,162
Total	—	11,454
Number of pupils for whom spectacles were prescribed	—	2,769

*These figures represent those from the two Ophthalmic Surgeons of the County Eye Service on the staff of the S. W., R. H. B.

GROUP 2.—DISEASES AND DEFECTS OF EAR, NOSE AND THROAT

	<i>Number of cases treated</i>	
	<i>by the Authority</i>	<i>otherwise</i>
Received operative treatment		
(a) for diseases of the ear	—	not known
(b) for adenoids and chronic tonsilitis	—	..
(c) for other nose and throat conditions	—	..
Received other forms of treatment	Not known but 2389 Treatments done	
Total number of pupils in schools who are known to have been provided with hearing aids		
(a) in 1956	2	not known
(b) in previous years	—	not known

GROUP 3.—ORTHOPAEDIC AND POSTURAL DEFECTS

	<i>by the Authority</i>	<i>otherwise</i>
Number treated in clinics or out-patient departments	(Only minor ailments if any)	not known

GROUP 4.—DISEASES OF THE SKIN (excluding uncleanness, for which see Table VIII).

					<i>Number of cases treated or under treatment during the year by the Authority</i>
Ringworm— (i) Scalp .. .. .	..	..	..	Not known, but 9 treatments done	
(ii) Body .. .. .	..	..	..	" " " 231	" "
Scabies .. .. .	..	..	..	" " " 42	" "
Impetigo .. .. .	..	..	..	" " " 2149	" "
Other skin diseases .. .. .	..	..	..	" " " 7132	" "
Total .. .. .	..	..	..	" " " 9563	" "

GROUP 5.—CHILD GUIDANCE TREATMENT

Number of pupils treated at Child Guidance Clinics under arrangements made by the authority	487
---	-----

GROUP 6.—SPEECH THERAPY

Number of pupils treated by Speech Therapists under arrangements made by the Authority	650
---	-----

GROUP 7.—OTHER TREATMENT GIVEN

(a) Number of cases of miscellaneous minor ailments treated by the Authority ..	Not known, but 18805 treatments done
(b) Pupils who received convalescent treatment under School Health Service arrangements	—
(c) Pupils who received B.C.G. vaccination ..	No official scheme
(d) Other than (a), (b) and (c) above (specify)	
1.....	—
2.....	—
3.....	—
4.....	—
5.....	—
Totals (a)—(d)	See (a) above

TABLE X.
DENTAL INSPECTION AND TREATMENT
CARRIED OUT BY THE AUTHORITY.

(1)	Number of pupils inspected by the Authority's Dental Officers:					
	(a) At Periodic Inspections	..	..	..	..	33,773
	(b) As Specials	..	..	..	..	1,935
				Total (1)	..	35,708
(2)	Number found to require treatment	..	..	..	..	23,829
(3)	Number offered treatment	..	..	..	..	18,008
(4)	Number actually treated	..	..	..	..	15,000
(5)	Attendances made by pupils for treatment	..	..	..	..	38,568
	(including 11(h) below)					
(6)	Half-days devoted to:	Periodic (School) Inspection				
		and				
		Treatment				
		(incl. Orthodontics)			..	6,596
(7)	Fillings:	Permanent Teeth	..	..	..	24,724
		Temporary Teeth	..	..	..	3,102
				Total (7)	..	27,826
(8)	Number of teeth filled:	Permanent Teeth	..	..	..	21,662
		Temporary Teeth	..	..	..	3,191
				Total (8)	..	24,853
(9)	Extractions:	Permanent Teeth	..	..	..	4,051
		Temporary Teeth	..	..	..	12,402
				Total (9)	..	16,453
(10)	Administration of general anaesthetics for extraction..				..	3,896
(11)	Orthodontics :					
	(a) Cases commenced during the year	..	..	..	..	333
	(b) Cases carried forward from previous year	..	..	..	..	375
	(c) Cases completed during the year	..	..	..	..	229
	(d) Cases discontinued during the year	..	..	..	..	29
	(e) Pupils treated with appliances	..	..	..	..	309
	(f) Removable appliances fitted	..	..	..	..	374
	(g) Fixed appliances fitted	..	..	..	..	7
	(h) Total attendances..	..	..	..	..	3687
(12)	Number of pupils supplied with artificial dentures	..	..	..	..	86
(13)	Other operations:	Permanent Teeth	..	..	..	14,349
		Temporary Teeth	..	..	..	3,387
				Total (13)	..	17,736

TABLE XI

SPEECH CLINICS

A.		
Number of cases on the register at the commencement of the year ..		408
Number of individual cases interviewed and/or treated		650
Number of attendances of cases		4479
Number of cases		
(a) Discharged		148
(b) Left (including transferred)		19
(c) improved but not yet ready for discharge		382
B.		
TYPES OF SPEECH DEFECT OR DISORDER DEALT WITH		
<i>(Classified according to the predominating aspect of the disturbance)</i>		
Defects of Articulation—		
e.g. Dyslalia		270
Defects of Voice—		
e.g. Excessive Nasality ..		18
Defects of Language—		
e.g. Aphasia		8
Defects of Communication—		
e.g. Stammer		119
Other Defects—		
e.g. Cleft Plate		34

TABLE XII
HANDICAPPED PUPILS.

	(1) <i>Blind</i> (2) <i>Partially Sighted</i>		(3) <i>Deaf</i> (4) <i>Partially Deaf</i>		(5) <i>Delicate</i> (6) <i>Physically Handicapped</i>		(7) <i>Educationally sub-normal</i> (8) <i>Mal-adjusted</i>		(9) <i>Epileptic</i>	Total (1-9)
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
A. Children <i>newly placed</i> in Special Schools or Boarding Homes	2	7	6	3	8	13	34	20	2	95
B. Children <i>newly assessed</i> as needing special educational treatment at Special Schools or in Boarding Homes..	—	5	1	4	6	16	82	22	1	137
C. (i) Children on the registers of special schools as (a) Day Pupils (b) Boarding Pupils ..	—	1	3	2	20	52	3	—	—	81
(ii) Children on the registers of independent schools under arrangements made by the Authority ..	22	16	23	10	3	16	150	—	4	244
(iii) Children boarded in Homes and not already included in (i) or (ii)	—	—	—	1	1	1	—	9	—	12
Total (C) ..	22	17	26	13	30	69	153	32	4	366
D. Children being educated under arrangements made under Section 56 of the Education Act, 1944										
(i) in hospitals ..	—	—	—	—	3	1	1	1	—	6
(ii) in other groups e.g. units for spastics	—	—	—	—	—	—	—	—	—	—
(iii) at home ..	—	2	1	2	19	15	9	—	—	48
E. Children requiring places in special schools										
(i) Total (a) Day .. (b) Boarding ..	—	—	—	—	—	—	2	—	—	2
(ii) Children (included above) who had not reached the age of 5	—	7	4	2	1	18	311	2	—	345
(a) awaiting day places	—	—	1	—	—	—	—	—	—	1
(b) awaiting boarding places ..	—	1	—	—	—	1	—	—	—	2
(iii) who had reached the age of 5 but whose parents had not consented to their admission to a Special School)..	—	—	—	—	—	—	—	—	—	—
(a) awaiting day places	—	—	—	—	—	—	—	—	—	—
(b) awaiting boarding places	—	1	—	2	1	2	213	—	—	219

Children reported to the Local Health Authority :

(a) Under Section 57 (3) (excluding any returned under (b))	33
(b) Under Section 57 (3) relying on Section 57 (4)	—
(c) Under Section 57 (5)	—
of the Education Act, 1944	35

TABLE XIII

**IMPROVEMENTS TO OFFICES, SANITATION ETC., CARRIED OUT
DURING THE YEAR ENDED 31st DECEMBER 1956**

County Primary Schools:

Alphington	..	..	Additional wash basins and hot water supply.
Aylesbeare	..	..	Conversion of Offices to water carriage new drainage system etc.
Bradford	..	..	Main water supply
Brixham, Furzeham Hill			Improvements to drainage
Buckland Brewer	..	..	Main water supply
Christow	..	..	Improvements to Offices
Dawlish Infants'	..	..	Improvements to Offices
Heanton Punchardon	..	..	Hot water supply to basins
Honiton	..	..	Hot water supply to basins
Kenton	..	..	New cloakroom and improvements to Offices etc.
Langtree	..	..	Main water supply
Newton St. Cyres	..	..	Improvements to Offices
Okehampton	..	..	Improvements to Offices
Paignton, Curledge Street			Improvements to Offices and hot water supply to basins
Parkham	..	..	Main water supply
South Brent	..	..	Main water supply
St. Giles-on-the-Heath	..	..	Improvements to drainage
Stoke Gabriel	..	..	Improvements to Offices
Teignmouth	..	..	Hot water supply to basins
Tiverton, Bampton Street			Additional wash basins

Voluntary Primary Schools:

Blackpool	..	..	New drainage etc.
Kenn	..	..	New cloakrooms and hot water supply to basins.
Low Trenchard	..	..	Main water supply
North Bovey	..	..	Additional wash basins
Sampford Peverell	..	..	Erection of new Offices etc.

Grammar Schools:

Crediton Grammar	..	..	Additional sanitary accommodation at Hostel
Totnes High School	..	..	New water main

County Secondary Schools:

Axminster	..	..	New Changing Rooms and Showers
Cullompton	..	..	Sanitary provision at Pavilion
Exmouth Boys'	..	..	New Cloakroom and additional wash basins
Tiverton	..	..	Staff lavatory accommodation
Torquay, Audley Park	..	..	Staff lavatory accommodation

Special Schools:

Bradfield	..	..	Improvements to drainage
Exmouth, Withycombe House	..	..	New cloakroom and drying room

TABLE XIV

SCHOOL CLINICS

Town	Address	Phone No.	Type of Clinic	$\frac{1}{2}$ -day Sessions		
				Week	Fort- night	Month
Alphington	Council School		Minor Ailment		1	
Appledore	Appledore Hall		Minor Ailment			1
Ashburton	Council School		Minor Ailment	1		
Axminster	Secondary Modern School	2146	Minor Ailment	1		
	" " "		Speech		1	
	Plaza " Cinema "	2123	Dental Vision	1		$\frac{1}{2}$
Bampton	Central Hall		Minor Ailment		1	
Barnstaple	19 (b) Alex. Road	3549	Minor Ailment	5		
	" "		Dental (whole-time)		21	
	" "		Speech	3		
	" "		Child Guidance	2		
	" "		Vision			1 $\frac{1}{2}$
Bideford	Coronation Road	1121	Minor Ailment	1		
	" "		Dental (part-time)	4		
	" "		Speech	3		
	" "		Vision			1
	C. of E. Institute		Minor Ailment	1		
Bovey Tracey	Wickham Hall		Minor Ailment		1	
Braunton	Parish Hall		Minor Ailment	1		
Brixham	Church House, Bolton Street		Minor Ailment	1		
	" " "		Vision			1
Buckfastleigh	Council School	3104	Minor Ailment	1		
Budleigh Salterton	Church Institute		Minor Ailment		1	
Colyton	Youth Club, High Street		Minor Ailment		1	
Combe Martin	Baptist Church Rooms ..		Minor Ailment		1	
Crediton	Newcombes	449	Minor Ailment	1		
	" "		Dental (part-time)	4		
	" "		Speech	1		
	" "		Vision			$\frac{1}{2}$
Cullompton	Baptist Chapel Schoolrooms		Minor Ailment		1	
Dartmouth	Mayors Avenue	245	Minor Ailment	1		
	" "		Dental		1	
	" "		Speech	1		
	" "		Vision			1
Dawlish	The Knowle, Barton Road	3356	Minor Ailment		1	
	" " " "		Vision			$\frac{1}{2}$
Exeter	Alice Vlieland Centre	54685	Child Guidance	4		
	" " " "		Dental (part-time Orthodontic)		1	
	" " " "		Vision			1
	" " " "		Speech	2		
	Royal Devon & Exeter Hospital	2261 & 59261	Dental (part-time)		1	
	" " " "		" " " "			
Exmouth	St. Clements, 142 Exeter Road	2610	Minor Ailment	3		
	" " " "		Dental (part-time)	7		
	" " " "		Speech	2		
	" " " "		Vision			$\frac{1}{2}$
	" " " "		Orthodontics			1
	" " " "		Remedial & Breathing Exercise		Occasional	
	Withycombe House		Speech	1		
Fremington	Parish Church Hall		Minor Ailments			1

Town	Address	Phone No.	Type of Clinic	$\frac{1}{2}$ -day Sessions		
				Week	Fort- night	Month
Holsworthy ..	Chapel Street Schoolroom		Minor Ailment			1
	"Secondary "Modern" School	30	Speech Vision	1		$\frac{1}{2}$
Honiton ..	Secondary Modern School	283	Minor Ailment	1		
	" " "		Dental	1		
	Mill Street " " "		Vision Speech			$\frac{1}{2}$
Horrabridge ..	Church Rooms		Minor Ailment		1	
Ilfracombe ..	4 Market Street	758	Minor Ailment	1		
	" " " "		Vision			$\frac{1}{2}$
	" " " "		Dental (part-time)	3		
	" " " "		Speech	1		
Ivybridge ..	Methodist Sunday School Room		Minor Ailment			1
Kingsbridge ..	Tresillian	2280	Minor Ailment	1		
	" " " "		Vision			
	" " " "		Dental (part-time)	3		
	Co. Primary School ..	2009	Remedial & Breathing Exercises		1	
Lifton ..	Methodist Church Rooms		Minor Ailment			1
Lynton ..	Jubilee Hall		Minor Ailment		1	
Morched Bishop ..	Memorial Hall		Minor Ailment		1	
Newton Abbot	Glencoe, Courtenay Park	377	Minor Ailment	2		
	" " " "		Vision		1	
	" " " "		Speech	2		
	" " " "		Dental (whole-time)		21	
Newton Abbot	Meadowside, Highweek Rd.	461	Minor Ailment	2		
Northam ..	Church Hall		Minor Ailment		1	
Okehampton ..	Fairplace Methodist Rooms		Minor Ailment		1	
	Secondary Modern School	97	Speech Vision	2		1
Paignton ..	Central Clinic, Midvale Rd.	27555	Minor Ailment	1		
	" " " "		Vision			2
	" " " "		Dental (part-time)	6		
	" " " "		Speech	3		
	Foxhole Inf. Hayes Road	57336	Minor Ailment		1	
Plympton ..	Congregational School ..		Minor Ailment	1		
	Secondary Modern School	2297	Speech	1		
	" " " "		Vision			1
	Church of England School		Speech	$\frac{1}{2}$		
	St. Maurice Co. Primary School		Speech	$\frac{1}{2}$		
	" " " "		Dental (part-time)		1	
Plymstock ..	Secondary Modern School	3327	Minor Ailment	1		
	" " " "		Vision			1
	" " " "		Dental (part-time)	5		
	" " " "		Speech	1		
	" " " "		Remedial & Breathing Exercises		1	
Roborough ..	Recreation Hut		Minor Ailment			2
	Maristow Special School	73178 (Plymouth)	Speech	2		
Seaton ..	Women's Institute		Minor Ailment		1	
	" " " "		Speech		1	
Sidmouth ..	St. Nicholas School ..		Minor Ailment	1		
	Woolbrook S.M. ..		Vision Minor Ailment			$\frac{1}{2}$ 2
South Brent ..	Church Hall		Minor Ailment		1	

Town	Address	Phone No.	Type of Clinic	$\frac{1}{2}$ -day Sessions		
				Week	Fort- night	Month
South Molton	99 East Street	29	Minor Ailment		1	
	" "		Speech	1		
	" "		Vision			1
	Secondary Modern School		Dental (part-time)	2		
Tavistock	Church Hall, West Street		Minor Ailment	1		
	" "		Vision			1
	" "		Speech	2		
Teignmouth	St. James Parish Hall		Minor Ailment	1		
	Teignmouth Hospital (Out-patients Dept.)		Vision			$\frac{1}{2}$
Tiverton	St. Andrew Street	2708	Minor Ailment	1		
	" "		Dental (part-time)	5		
	" "		Speech	1 $\frac{1}{2}$		
	" "		Vision			$\frac{1}{2}$
	" "		Remedial & Breathing Exercises	1		
	" "		Orthodontics			1
Torquay	Castle Road Clinic	4152	Minor Ailment	5		
	" "		Speech	2		
	" "		Dental (whole-time)	15		
	" "		Vision	1		
	Barton Clinic	87274	Child Guidance	4		
	" "		Minor Ailment	5		
	" "	87920	Dental (whole-time)		21	
	" "		Speech	1		
Torrington	Audley Park School		Minor Ailment	5		
	West Hill School	87090	Minor Ailment	5		
	Church House, New Street	2186	Minor Ailment	1		
	" "		Speech	1		
Totnes	Secondary Modern School		Vision			$\frac{1}{2}$
	Borough Park	2078	Minor Ailment	1		
	" "	2392	Dental (part-time)	4		
Villand	Secondary Modern School		Vision			1
	Bradfield Sp. School		Speech		1	
Voolacombe	Methodist Hall		Minor Ailment		1	
Wearmouth	Chapel Rooms		Minor Ailment			1

The Minor Ailment sessions include facilities for Diphtheria Immunization as required.

TABLE XV
CAUSES OF DEATH AT DIFFERENT PERIODS OF LIFE IN THE ADMINISTRATIVE COUNTY OF DEVON, 1956

Age Group	Sex	Tuberculosis and other Infectious Diseases 1—9	Cancer and other Malignant Diseases 10—15	Vascular Lesions of Nervous System 17	Heart and Circulatory System 18—21	Respiratory (excluding Tuberculosis) 22—25	Stomach and Digestive System 26—27	Genito-Urinary 28—29	Maternal 30	All Others 16, 31, 32	Accident Suicide Etc. 33—36	Total Deaths
0—	M F	1 1	— —	— —	— —	11 9	1 —	— —	— —	63 40	3 2	79 52
1—	M F	1 3	2 1	— —	— —	3 —	— 1	— —	— —	5 5	4 3	15 13
5—	M F	1 2	1 4	— —	1 —	1 1	— —	1 —	— —	12 6	5 2	22 15
15—	M F	1 —	5 1	1 —	3 —	2 3	— —	— 2	— 1	6 4	18 1	36 12
25—	M F	9 4	27 23	6 8	11 6	7 9	1 —	4 3	— 2	21 22	32 3	118 80
45—	M F	34 11	211 213	59 103	284 137	81 34	9 4	11 10	— —	51 64	47 28	787 604
65—	M F	12 8	201 178	131 181	423 390	108 62	15 9	35 10	— —	59 84	16 20	1,000 942
75—	M F	10 5	148 203	258 410	754 968	159 206	21 19	61 12	— —	93 201	23 60	1,563 2,084
Totals	M F	69 34	631 623	455 702	1,476 1,501	372 324	47 33	112 37	— 3	310 426	148 119	3,620 3,802

Table XVI. STATISTICS—COUNTY OF DEVON—1956

Area	Districts	Populations (Est. Mid 1956 Home)	Births Rates per 1,000 Population			Infant Deaths		Tuber- culosis and Other Infec- tious Diseases 1—9	Cancer and Other Malign- ant Diseases 10—15	Vascular Lesions of Nervous System 17	Heart and Circula- tory System 18—21	Respir- atory (exclud- ing Tuber- culosis) 22—25	Stomach and Diges- tive System 26—27	Genito- Urinary 28—29	Maternal 30	All Others 16, 31, 32	Accident Suicide Etc. 33—36	Total Deaths		
			No.	Crude Rate	Corr'd Rate	No.	No.											No.	Crude Rate	Corr'd Rate
1	Exmouth U.D.	17,820	258	13.36	16.03	5	4	1	44	55	130	31	4	8	—	27	11	311	17.45	10.99
	Budleigh Salterton U.D.	3,860	37	9.59	13.23	1	1	1	14	12	30	3	1	1	—	7	1	70	18.13	9.97
	St. Thomas R.D.	33,110	443	13.38	15.25	7	6	7	71	55	222	77	9	8	—	46	19	514	15.52	10.24
2	Honiton M.B.	4,510	72	15.96	21.55	—	—	—	8	7	21	2	—	2	—	6	2	48	10.64	9.90
	Ottery St. Mary U.D.	4,160	44	10.58	11.11	2	1	1	7	7	17	4	—	—	—	4	1	41	9.86	7.89
	Sidmouth U.D.	9,780	81	8.28	11.01	1	—	3	30	34	84	14	1	4	—	11	7	188	19.22	11.15
	Seaton U.D.	2,970	29	9.67	12.18	—	—	—	11	10	23	3	2	—	—	3	4	56	18.86	9.81
	Axminster R.D.	14,270	172	12.05	13.86	8	7	3	29	39	60	26	4	3	—	19	10	193	13.52	10.82
	Honiton R.D.	6,920	79	11.42	12.90	—	—	—	20	9	19	4	2	3	—	10	2	69	9.97	9.37
3	Tiverton M.B.	11,650	190	16.31	16.64	4	4	3	23	37	54	10	—	3	—	15	6	151	12.95	9.84
	Crediton U.D.	4,220	74	17.53	16.65	4	4	—	8	11	22	10	1	2	—	11	1	66	15.64	12.67
	Crediton R.D.	9,880	149	15.20	17.34	1	1	1	21	15	31	8	—	4	—	15	4	99	10.10	9.29
	Tiverton R.D.	20,600	332	16.12	17.73	3	3	4	41	40	86	28	2	6	—	22	7	236	11.46	10.43
4	Barnstaple M.B.	15,790	233	14.76	15.35	4	3	2	41	25	109	12	2	1	1	21	6	220	13.93	12.26
	South Molton M.B.	3,100	35	11.29	12.42	1	1	1	4	7	19	5	—	2	—	3	7	48	15.48	12.54
	Ilfracombe U.D.	8,780	104	11.84	13.64	3	3	—	23	24	52	9	1	—	—	9	4	122	13.89	10.14
	Lynton U.D.	1,720	13	7.56	7.48	—	—	1	3	6	11	3	—	1	—	—	—	25	14.53	11.68
	Barnstaple R.D.	24,070	343	14.25	16.39	4	3	—	57	31	150	16	6	6	—	20	16	302	12.55	10.92
	South Molton R.D.	8,920	118	13.43	15.58	2	2	—	19	14	36	13	—	2	—	13	7	104	11.66	10.84
5	Bideford M.B.	10,200	141	13.82	14.65	2	1	2	29	25	78	19	—	2	—	7	6	168	16.47	12.95
	Gt. Torrington M.B.	2,840	30	10.56	12.04	—	—	—	9	6	26	5	1	2	—	4	2	55	19.37	12.59
	Holsworthy U.D.	1,610	31	19.25	18.48	2	2	—	3	4	13	5	—	2	—	6	1	34	21.12	13.09
	Northam U.D.	6,630	66	9.95	11.04	—	—	1	8	15	51	10	1	—	1	2	2	91	13.72	10.56
	Bideford R.D.	5,280	72	13.64	15.28	3	3	—	10	11	71	8	1	2	—	8	2	59	11.17	10.16
	Torrington R.D.	7,190	91	12.66	15.07	1	1	—	16	11	38	5	1	1	—	14	2	88	12.24	11.02
	Holsworthy R.D.	5,930	83	13.99	15.81	1	—	2	9	11	39	4	1	—	—	5	2	73	12.31	10.83
	Okehampton M.B.	3,900	48	12.31	13.17	4	4	1	7	4	26	7	2	2	—	10	1	60	15.38	6.77
6	Tavistock U.D.	6,190	89	14.38	16.68	—	—	—	10	18	42	9	3	1	—	16	3	102	16.48	9.89
	Broadwoodwidge R.D.	2,040	33	16.18	17.15	1	—	1	3	2	4	3	—	—	—	2	—	15	7.35	8.67
	Okehampton R.D.	12,060	177	14.68	17.47	2	2	4	29	19	62	22	1	4	—	21	4	166	13.76	11.28
	Tavistock R.D.	15,640	228	14.58	17.93	4	3	3	36	29	77	21	2	1	—	15	7	191	12.21	10.99
7	Kingsbridge U.D.	3,140	39	12.42	13.54	2	2	—	9	5	24	6	2	2	—	5	2	55	17.52	15.24
	Salcombe U.D.	2,460	18	7.32	8.86	1	1	—	8	5	12	3	—	—	—	4	—	32	13.01	9.11
	Kingsbridge R.D.	11,990	187	15.95	18.08	4	3	3	36	18	51	14	1	3	—	18	8	153	12.76	10.72
	Plympton St. Mary R.D.	33,610	467	13.89	15.97	6	4	12	75	63	164	28	—	8	—	47	16	413	12.29	10.94
8	Dawlish U.D.	7,130	70	9.82	11.09	—	—	—	28	20	36	5	—	2	—	9	3	103	14.45	10.20
	Newton Abbot U.D.	17,120	224	13.08	13.47	10	7	5	46	37	69	22	4	10	—	26	5	224	13.08	11.12
	Teignmouth U.D.	10,510	126	11.99	14.27	3	2	3	27	27	78	13	2	4	—	19	5	178	16.94	10.33
	Newton Abbot R.D.	25,620	299	11.67	13.65	7	4	4	63	67	132	41	6	6	—	40	14	373	14.66	12.17
9	Torquay M.B.	50,000	568	11.96	13.28	11	5	11	132	140	338	92	9	14	1	76	30	843	16.86	12.14
10	Totnes M.B.	5,540	66	12.91	13.68	3	1	1	19	14	23	4	—	2	—	26	2	91	16.43	11.34
	Ashburton U.D.	2,710	45	16.61	18.10	1	—	1	12	6	15	5	2	—	—	3	1	45	16.61	12.29
	Buckfastleigh U.D.	2,460	27	10.98	12.96	—	—	1	7	8	9	2	1	—	—	—	3	31	12.60	9.70
	Totnes R.D.	13,950	198	14.19	16.46	5	4	3	26	28	108	20	4	8	—	31	9	237	16.99	9.68
11	Dartmouth M.B.	6,000	84	14.00	15.40	1	—	2	20	18	18	1	1	1	—	10	2	73	12.17	10.59
	Brixham U.D.	9,120	101	11.07	12.40	4	2	3	23	19	47	11	—	6	—	18	5	132	14.47	11.43
	Paignton U.D.	25,780	251	9.73	12.07	4	3	12	80	89	204	33	—	10	—	32	14	474	18.39	11.59
	Administrative County	512,700	6,645	12.96	14.77	132	97	103	1,254	1,157	2,977	696	80	149	3	736	267	7,422	14.48	11.15

